Medical Economics

PUBLISHED EVERY OTHER MONDAY • ISSUE OF MARCH 31, 1958

Crisis in the Supply of Doctors

This Form Turns Charges Into Cash

Improve Your Appointment System!

Is the Right Man Covering for You?

How Much to Varnish the Truth

Tax Savings You're Likely to Overlook

Medical Economics

NEWS BRIEFS

100,000 ILLEGAL ABORTIONS EVERY YEAR are being done by M.D.s, if the women interviewed by the Institute for Sex Research are to be believed. This is the group made famous by Dr. Alfred C. Kinsey. Its new report will be out in May.

RECESSION? It's more an excuse than a real reason for not paying doctors, medical collection agencies report. Details in next issue.

PRIVATE EYE has been hired by the Los Angeles County Medical Association to check up on its own members. "We are employing a private investigator," explains Dr. Donald Cass, "in hopes of bringing to a close the activities of some unethical physicians among our members."

DOCTORS' DONATIONS to medical schools may be falling off, but corporate gifts are increasing. The National Fund for Medical Education now collects more than $2,000,000 annually.

NEWS BRIEFS

PROFESSIONAL COURTESY PROBLEM: People who work in hospitals now total 1,300,000. Are they entitled to free care or reduced rates from doctors? Most medical men think so, according to a new check-up by this magazine.

PAID-UP HEALTH INSURANCE is what people over 65 need, the Westchester (N.Y.) Medical Bulletin points out. And if they can't arrange to pay for it before 65, "a contributory plan administered through the Social Security machinery" may be the only practical answer.

DOCTORS' PENT-UP FEELINGS about malpractice attorneys are finally exploding in public. Newspapers all over the U.S. this month featured Dr. Emil Seletz's scathing denunciation of such lawyers. They're turning liability suits against doctors into "legalized blackmail," he charged; their "sole purpose is to aid in the hold-up and run with the loot."

$25,000,000 SEARCH for an anti-cancer chemical is getting off the ground. Latest developments: Half the National Cancer Institute's budget is earmarked for the hunt; drug firms will contribute compounds for testing without losing their patent rights; 165 hospitals will test promising compounds on patients.

NEW DRUG EVERY DAY: That's the rate at which you're getting new pharmaceutical products to prescribe. Latest ten-year total: 3,686.

IF TAX CUTS COME, they may save us from something worse than recession, according to Dr. Fred Sternagel, president of the Iowa State Medical Society. "In 1950, taxes took one dollar in four from our earnings," he says. "Today, taxes take one dollar out of three." That's 33% taxation—and as he sees it, "39% taxation means socialism, 42% means communism, and more than 44% means slavery."

FED UP WITH FEE SCHEDULES? A Blue Shield plan in Wisconsin gets along without them. It pays doctors' usual fees, covers 25,000 subscribers, costs them 15% more than standard.

THEY'D RATHER GIVE IT AWAY: Nearly half of California's private physicians are now boycotting the new indigent care program in that state. Instead of accepting government funds and government red tape, they say they'll give free service or arrange local charity hospital care. Revolt against "socialized medicine at its worst" began in Santa Barbara County, now has spread to fifteen others. The New Mexico Medical Society has taken a similar stand.

NEWS BRIEFS

THEY'VE FINALLY DONE IT: Organized a doctor-owned malpractice insurance company. Colorado M.D.s raised $75,000 capital, reinsured through Lloyds of London, are now offering coverage at 25% below other companies' premium rates.

YOUR 60-HOUR WORK WEEK may stretch to 65 or 70 hours in the next five years. That's what can happen when population grows faster than doctor population. And it will happen, the experts say, unless we drastically step up doctor production. Details on p. 67.

LOW-COST LIFE INSURANCE without medical exam is going over well in Chicago and New York. To get the medical waiver, at least 50% of all medical society members in a given age group must sign up. Many age groups in Chicago have already qualified; in New York, they expect to qualify soon. It's 5-year-term insurance that can be renewed once or converted.

NEW MEDICAL REPORT FORM has been designed by the Association of Casualty and Surety Companies. It's a cinch for the physician to fill out—but he may never get the chance. Though the model form has been distributed to all 134 member companies, only 17 have said they'd use it after supplies of their own forms run out.

When you need more minutes in your workday

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McGRAW EDISON

Medical Economics

INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS, MAR. 31, 1958

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MORE ►

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MEDICATION

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TETRACYCLINE PHOSPHATE COMPLEX WITH PHENYLTOLOXAMINE AND APC

Each TETREX-APC WITH BRISTAMIN Capsule contains:

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(tetracycline HCl activity)

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A dependable antihistamine

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Dosage: *Adults:* 2 capsules at onset of symptoms, followed by 2 capsules 3 or 4 times a day for 3 to 5 days. *Children, 6 to 12 yrs.:* One-half adult dose.

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just 1 small capsule-shaped tablet daily

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Vitamin B_{12} Activity Concentrate	2 mcg.
Folic Acid	0.25 mg.
Niacinamide	20 mg.
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Bottles of 100 and 1000. For your patient's convenience, *Engran Term-Pak* provides 250 tablets—enough to last until term—in a handsome reusable glass jar plus a purse-size dispenser.

Reference: 1. Tompkins, W. T. in Wohl, M. G. and Goodhart, R. S.: *Modern Nutrition in Health and Disease*, Lea & Febiger, Philadelphia, 1955, p. 886.

Advantages

- specifically formulated for the mother-to-be
- generous amounts of 11 vitamins and 8 minerals
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Letters

News Up Front

SIRS: Hooray for your new feature, "News Briefs"! It's a quick and meaty summary of things that we harassed doctors want to know about.

Andrew J. Smatko, M.D.
Santa Monica, Calif.

Call to Arms

SIRS: Your round-up of comments on Attorney Melvin M. Belli's views is fine—except for the conciliatory statement by Dr. T. Stacy Lloyd that concludes the article. Conciliation in this instance is not the sentiment of medicine. The California attorney's campaign for higher and higher malpractice awards is pernicious, and I see no reason to politely evade the issue. Let's fight him!

Herbert Berger, M.D.
Staten Island, N.Y.

Liability Limits

SIRS: As you pointed out, The Medical Protective Company is raising the relatively low limits of its malpractice insurance. We'll continue, however, to recommend moderate coverage. For our experience, the greatest in the professional liability field, shows that moderate coverage means only moderate losses. There were fewer claims and suits brought against our policyholders in 1957 than in any year during the past decade. The average damage loss was little more than one-third of the average policy's $5,000 limit.

Plaintiffs' attorneys *do* set their sights according to how much coverage the doctor has. Hence our philosophy: Insurance that suffices is far better than insurance that entices.

T. E. Haberkorn
The Medical Protective Co.
Fort Wayne, Ind.

Congressional Paupers

SIRS: Your interview with Representative Forand, "Front Man for Federal Health Insurance," clearly shows the thinking of an individual who's been feeding at the public trough for many years. If he's like some public officeholders

in my area, I presume that whenever he wants medical care he goes to the nearest V. A. hospital. There, after taking a pauper's oath, he gets treated at your expense and mine.

M.D., New York

More on Social Security

SIRS: The legal profession, and others previously excluded from Social Security, woke up and are now included.

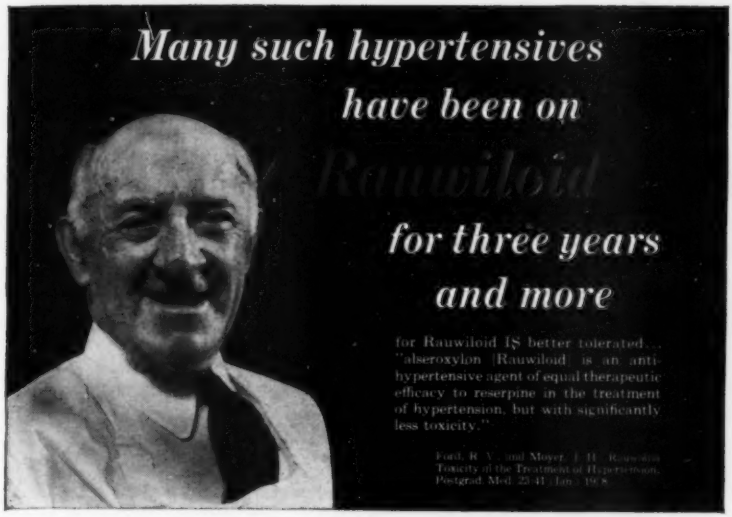
Are we physicians such supermen that we don't need the same protection?

At present I am helping two doctors' widows who are without Social Security benefits. One is working, though past 65 and not well. The other, also in her late sixties, is a semi-invalid. A monthly Social Security check would be good medicine for both.

As an employer, I have contributed to Social Security since its inception. As a result, I am now receiving some compensation for services to beneficiaries who, before Social Security, would no doubt have been among my charity patients.

F. C. Christensen, M.D.
Racine, Wis.

SIRS: To get Social Security, we practicing physicians will have to go over the heads of our medical organizations. These are mainly controlled by older physicians who attained financial security before the days of high Federal income



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STABLE! READY TO USE!

A Superior Oral Penicillin for Children

SUPPLIED: *Cherry flavor* —300,000 units per 5-cc. teaspoonful, bottles of 2 fl. oz.
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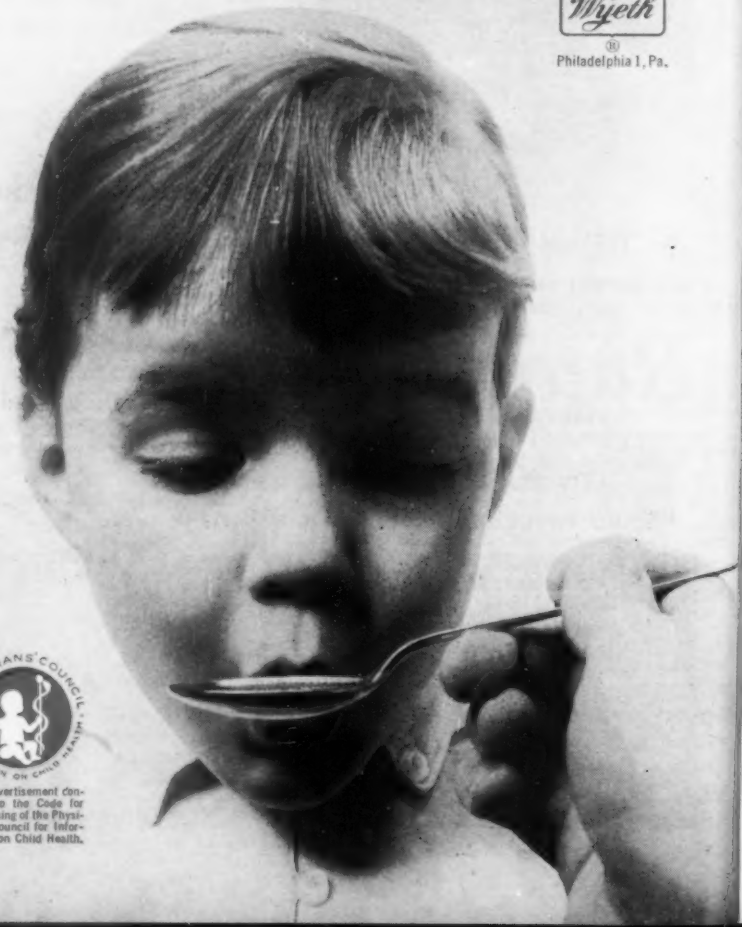

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taxes. They're the only ones who can afford the time to take part in medical society affairs. They don't speak for the rank and file.

I suggest we speak for ourselves —by writing directly to our congressmen and senators.

Paul K. Good, M.D.
Altoona, Pa.

Specialists and People

SIRS: One thing that's changed the old specialist-population ratios is the speed with which a specialist's reputation spreads. In recent years, I've spent much time in a small town. I've observed that many people there are loud in their praise of their specialist in the nearest city. They say they get better care at no more cost—or even less—than at home, and everybody listens.

And everybody's interested. From reading newspaper and magazine articles on health and medicine, people today have a surprising knowledge of most diseases and treatments. They talk intelligently of all kinds of operations—and of the various specialists who perform them.

B. T. Beasley, M.D.
Atlanta, Ga.

How to Raise Fees

SIRS: How to advise patients of fee increases? I've worked out the following solution:

At the end of a regular patient's first visit after the fee increase—be it one day or one year after—he's

told the increase has become effective. But he's also told that since he came to me expecting the previous fee scale, he'll be charged at that former level. For all subsequent services, though, he'll be charged at the new rate.

All my patients have agreed that this seems a fair method.

S. Theodore Sussman, M.D.
New Rochelle, N.Y.

No Income Tax

SIRS: I'd like to know the source of the figure you publish as New Hampshire's income tax. This state has none.

William F. Putnam, M.D.
Lyme, N.H.

A reputable firm of tax consultants supplied the MEDICAL ECONOMICS *figure. Evidently someone read too hurriedly a rather ambiguous statute that deals with New Hampshire's tax on certain categories of stock dividends.*—ED.

Safe Assumption

SIRS: The bald-headed man may sell hair tonic, and the shoemaker may have barefoot children. But can the doctor who's visibly in poor health prosper?

Not, I believe, unless he's some kind of a genius.

Sometimes a physician thinks he can help the patient by confessing

No other low-cost x-ray unit has all these features

Only G-E PATRICIAN gives you such economy of purchase . . .

FULL-POWER X-RAY GENERATOR	200-ma, 100-kvp, full wave power to "stop" involuntary patient movement.
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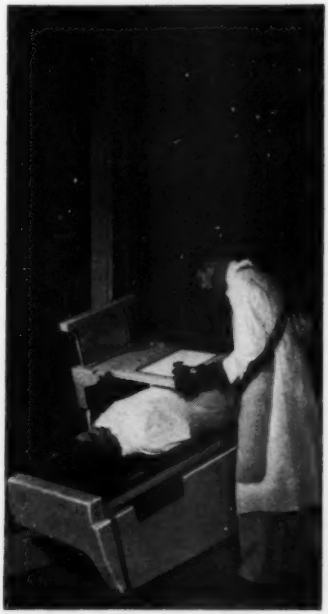

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his own disabilities. The patient is then supposed to say to himself: "Well, if the doctor can have it and get along so well with it, I guess my own trouble isn't too serious."

But what he probably says to himself is: "Some doctor! Can't even cure himself!" Or else: "I came to tell him *my* troubles. I'm not interested in his."

For the physician, Shakespeare's line might well be paraphrased: Assume good health if you have it not.

Henry A. Davidson, M.D.
Cedar Grove, N. J.

Doctors and Aides

SIRS: As to "What Working Hours for Doctors' Aides?" our management firm advises doctors to aim at giving their aides a forty-hour week. Regular overtime, we tell our doctor-clients, indicates either insufficient help or poor organization. What's more, it's bad for morale.

We suggest the doctor let it be understood that if the girl doesn't gripe at occasional late hours, *he* won't gripe at occasional paid absences for important family events. We advise three half-days a year for such things. We call these half-days "bisques." (As every golfer knows, a bisque is a stroke you can take any time you please during the round.)

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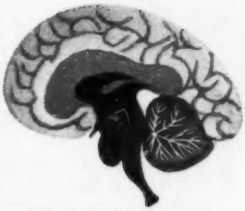
Professional Management
Southern Pines, N.C.

END

relaxes both mind & muscle

without impairing mental or physical efficiency



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Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets. *Usual dosage:* One or two 400 mg. tablets t.i.d.

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tranquilizer with muscle-relaxant action

2-methyl-2-n-propyl-1,3-propanediol dicarbamate

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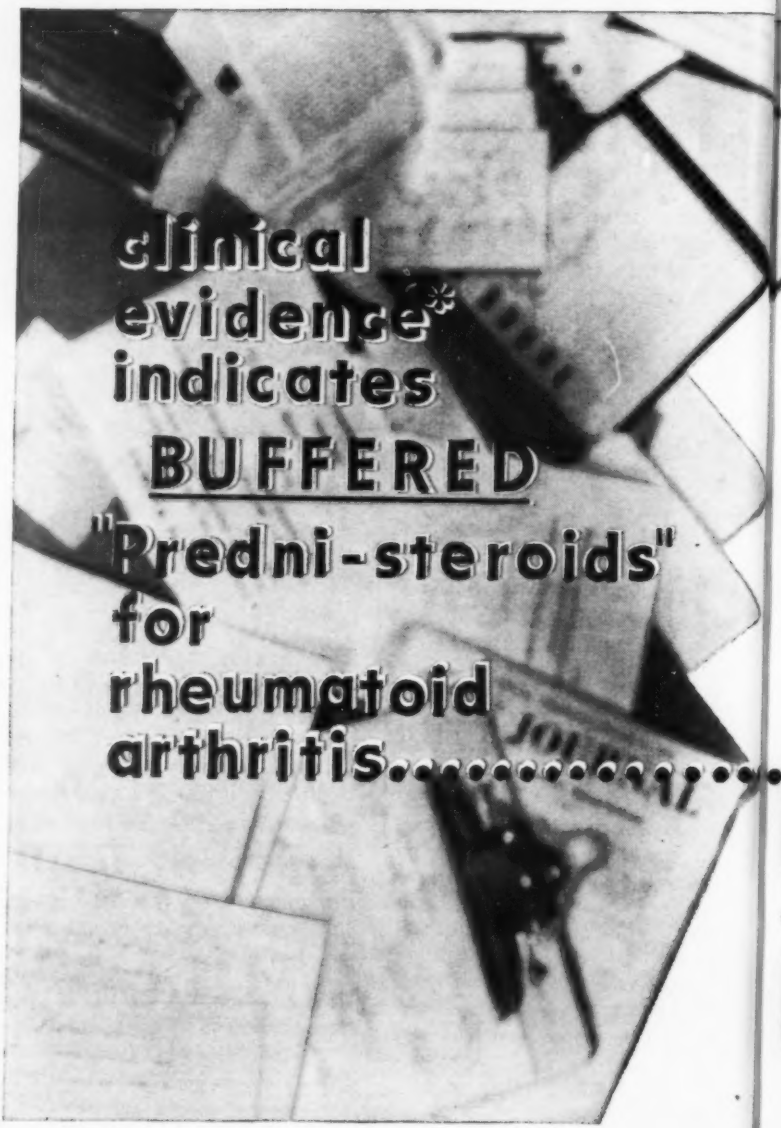
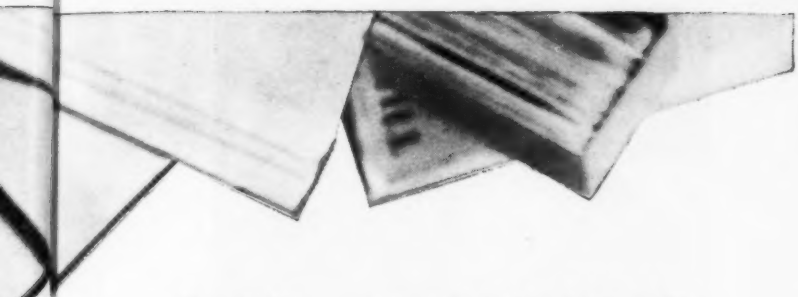

clinical
evidence*
indicates
BUFFERED
"Predni-steroids"
for
rheumatoid
arthritis.....



Gastric distress accompanying "predni-steroid" therapy is a definite clinical problem—well documented in a growing body of literature.*

*"It is our growing conviction that all patients receiving oral steroids should take each dose after food or with adequate buffering with aluminum or magnesium hydroxide preparations."—Sigler, J. W. and Ensign, D. C.: J. Kentucky State M. A. 54:771 (Sept.) 1956.

*"The apparent high incidence of this serious [gastric] side effect in patients receiving prednisone or prednisolone suggests the advisability of routine coadministration of an aluminum hydroxide gel."—Bollet, A. J. and Bunim, J. J.: J. A. M. A. 158:459 (June 11) 1955.

One way to make sure that patients receive full benefits of "predni-steroid" therapy plus positive protection against gastric distress is by prescribing CO-DELTRA or CO-HYDELTRA.

Co-Deltra.

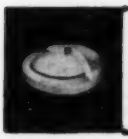
PREDNISONE BUFFERED

multiple compressed tablets

provide all the benefits of "Predni-steroid" therapy— plus positive antacid protection against gastric distress

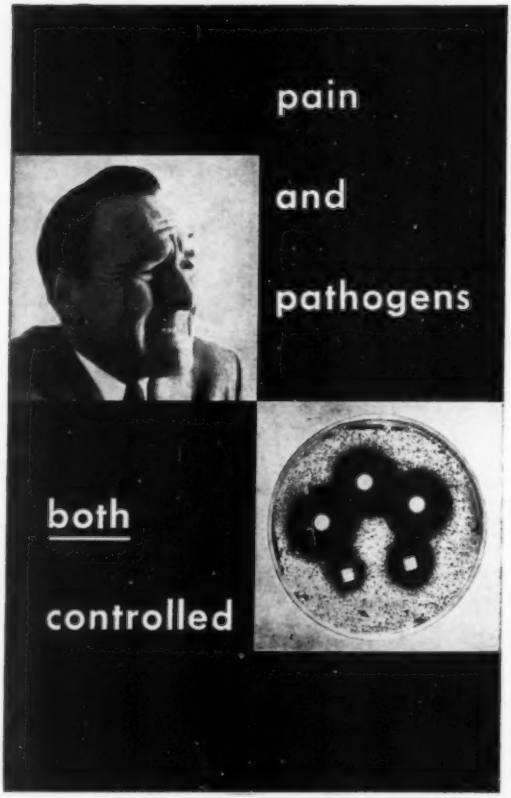
Co-Hydeltra.

PREDNISOLONE BUFFERED



2.5 mg. or 5.0 mg. of prednisone or prednisolone, plus 300 mg. of dried aluminum hydroxide gel and 50 mg. magnesium trisilicate, in bottles of 30, 100, and 500.

MERCK SHARP & DOHME Division of MERCK & CO., Inc., Philadelphia 1, Pa.



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News

Donations From Doctors Fall Short of $1,000,000

All last year the American Medical Education Foundation was busy collecting money from doctors. One-third of all active U. S. doctors made donations—an increase of some 4,000 over 1956. But total contributions, which have to be divided among eighty-five medical schools, amounted to a bit less than $1,000,000.

Executive Secretary John Hedback notes that if the checks dated December 31 could have been included, the million-dollar mark would have been surpassed. Apparently, Hedback comments, many doctor-donors don't realize that checks must be *cleared* during the tax year, not just written, to be deductible for that year.

Slightly more than half the money was earmarked by the donors for particular medical schools. Such contributions ranged from $100 for the University of California School of Medicine, San Francisco, to $45,399.71 for the College of Medical Evangelists.

Despite the A.M.E.F.'s efforts, grants from *un*designated funds won't pay *one* faculty salary. In fact, they'll scarcely pay a couple of test-tube washers.

Hospitals May Take Rap For Your Liability

Hospitals may soon be trying even harder to supervise staff physicians' activities. That's because before long they may find themselves considered legally liable for a private practitioner's negligence within their walls.

This prediction comes from Charles Haydon, a prominent New York attorney. There's an "expansionist trend . . . to hold hospitals liable," he observes. Already, courts in many states make them fully responsible for malpractice committed by internes, residents, and other employed physicians. Haydon believes that hospital responsibility for the in-hospital neg-

ligent acts of private practitioners is "one of the very next areas which the courts will be called upon to explore."

What yardstick will the courts use to measure a hospital's liability in such cases?

Haydon thinks they'll chiefly consider whether the malpractice occurred under circumstances that "might have been controlled and governed by the hospital." This, of course, may force law-conscious institutions to make greater efforts to "control and govern" the private doctors who use their facilities.

'Savage Caricature' Makes Some Doctors Boil

"Doctors' Patients See a Split Personality," said the headline in Business Week. As for the doctor-readers, some of them saw red. "Savage" and "slanderous" were among the words they used to describe the caricature that hung right under the headline (*see opposite page*).

The sketch was meant to be "facetious," the magazine said. It was based on "extreme opinions" that "aren't at all rational." But some of the same opinions cropped up in the accompanying article—a long, serious analysis of "the fallen reputation of the U.S. physician." Said Business Week:

One part of th. public today still thinks most doctors are "selfless, sincere, loyal, and sympathetic." But another part—"by far the larger if you're to believe the snap answers of most of the people you meet"—thinks the profession now consists "almost entirely of men who are avaricious, self-seeking, inhuman, lackadaisical, and hypocritical."

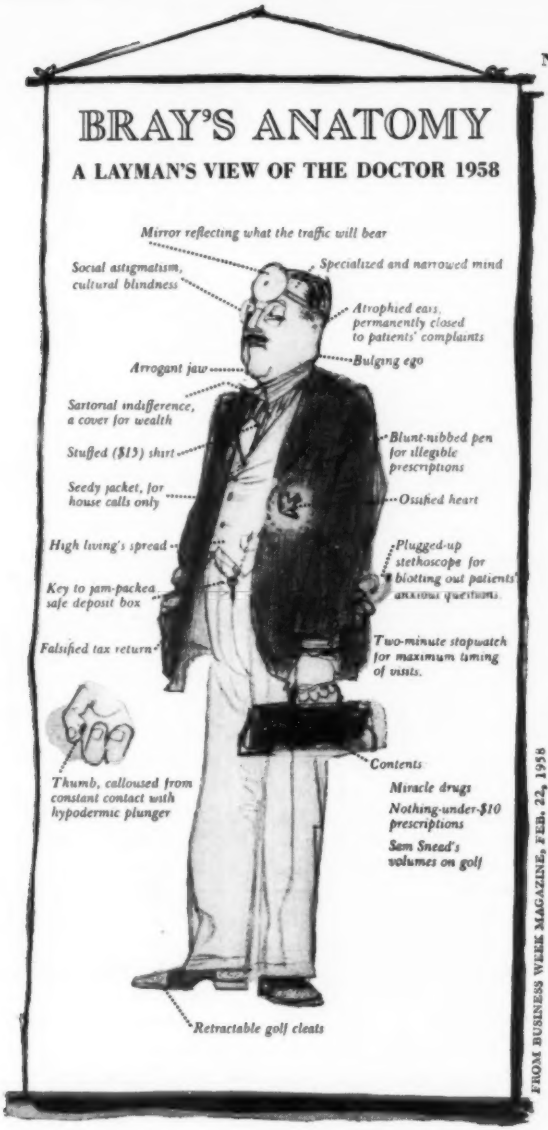
Closed-Panel Plans Lose 'Popularity' Contest

Closed panel medicine has made one of its strongest showings in New York. And the Blue plans there have been widely criticized recently because of their appeals for rate hikes. Yet New York workers who have just been given a choice between Blue Shield and closed-panel medicine have selected Blue Shield three to one.

The stage was set for this unusual popularity contest when New York State initiated a new and flexible health insurance program for its employes. Insurance costs are divided between the state and the worker. Each civil servant has much latitude in choice of plan.

If he wants commercial major medical insurance, he can have it. If he wants to include his dependents, he can. Blue Cross is the only hospitalization offered him. But if he lives in an area where there's a closed panel plan, he may choose it over Blue Shield.

Of the 65,000-odd employes faced with this last choice, the great


BRAY'S ANATOMY
A LAYMAN'S VIEW OF THE DOCTOR 1958
Mirror reflecting what the traffic will bear
Social astigmatism, cultural blindness
Specialized and narrowed mind
Atrophied ears, permanently closed to patients' complaints
Bulging ego
Arrogant jaw
Sartorial indifference, a cover for wealth
Stuffed ($15) shirt
Blunt-nibbed pen for illegible prescriptions
Seedy jacket, for house calls only
Ossified heart
High living's spread
Plugged-up stethoscope for blotting out patients' anxious questions
Key to jam-packed safe deposit box
Falsified tax return
Two-minute stopwatch for maximum taming of visits.
Contents
Miracle drugs
Nothing-under-$10 prescriptions
Sam Sneed's volumes on golf
Thumb, calloused from constant contact with hypodermic plunger
Retractable golf cleats
FROM BUSINESS WEEK MAGAZINE, FEB. 22, 1958

majority have already made up their minds. About 13,000 have signed up for Group Health Insurance, Inc. coverage, and another 2,000 have chosen the Health Insurance Plan of Greater New York (H.I.P.). The rest—some 76 per cent—have picked Blue Shield.

Heart Fund Protests United Fund Tactics

A call for help went out to doctors last month from the American Heart Association. It wants the medical profession to "help preserve its own freedom in the future" by helping the voluntary health agencies preserve theirs now.

The health agencies are under severe pressures and coercion to join United Funds," says Dr. Robert W. Wilkins, Heart Association president. "The rough pressure methods . . . have been almost incredible." For example, in soliciting money for heart disease, cancer, and polio, United Funds have led the public to believe that the respective voluntary health agencies will actually get the funds, says Dr. Wilkins. This "despite advance public declarations by the voluntary agencies that they must decline such funds and will continue to conduct their independent campaigns."

United Funds have also proclaimed that methods "with teeth in them" will be used against agencies that don't join in, Dr. Wilkins charges. "Their tactics have included economic threats against, and boycotts of, many private individuals . . . Thus they tell the public . . . where to give, when to give, and often how much to give."

"United Fund people may understand local charity needs," says Dr. Wilkins, "but they know nothing about the requirements of the nationally coordinated programs of medical research."

If doctors let them get away with it, he concludes, medical research will suffer. And "the result will be the needless loss of hundreds of thousands of lives."

What It Costs Now To Fly to Europe

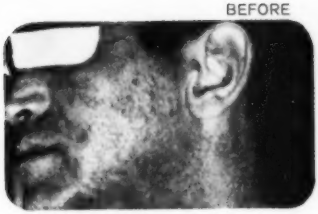
Bound for a medical meeting in Europe this spring or summer? Don't be bamboozled by advertisements telling you how cheap it is to fly. The airlines have actually *raised* their rates. But they've added a new "economy class" seat that's slightly less expensive than "tourist class" used to be.

You now can choose from four types of accommodations instead of three. On a one-way ticket from New York to London, here's what you pay and what you get:

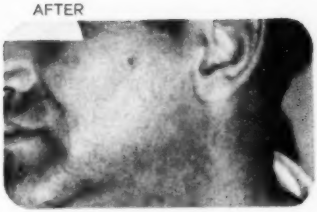
Economy class: Seats are 34 inches apart. There's no galley; only cold sandwiches are served. Cost: $252.

MORE▶

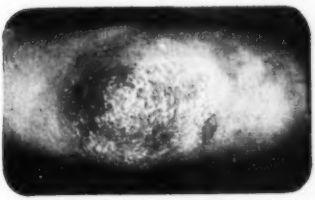
BEFORE AFTER



impetigo

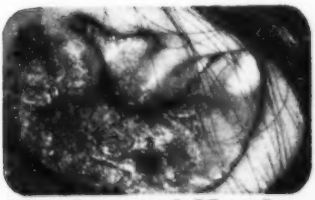


CONTROL THESE SKIN CONDITIONS

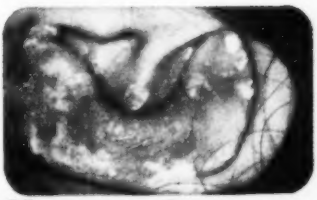


acute contact eczema

AND MANY MORE



infectious eczematoid dermatitis



Vioform®-Hydrocortisone Cream

soap-and-water eczema

Also newly available: VIOFORM LOTION, for patients in whom hydrocortisone is not indicated. For supply of Vioform-Hydrocortisone and Vioform Lotions, write P.O. Box 277, CIBA, Summit, N. J. Request must be made on physician's letterhead or Rx blank.

now also available as a **Lotion**

Supplied: VIOFORM-HYDROCORTISONE *Cream*, containing iodochlorhydroxyquin 3% and hydrocortisone 1% in a water-washable base; tubes of 5 and 20 Gm. *Lotion*, plastic squeeze bottles of 15 ml. VIOFORM *Lotion*, 3%; plastic squeeze bottles of 80 ml.

CIBA SUMMIT, N J

VIOFORM® (iodochlorhydroxyquin CIBA)

TAKE A NEW LOOK AT ALLERGENS* TAKE A LOOK AT NEW DIMETANE®

There is no antihistamine better than DIMETANE for allergic protection. DIMETANE gives you good reasons to re-examine the antihistamine you are now using: unexcelled potency, unsurpassed therapeutic index and relative safety... minimum drowsiness or other side effects. Has been effective where other antihistamines have failed. DIMETANE Extentabs® (12 mg.) protect for 10-12 hours on one tablet. Also available in Tablets (4 mg.), Elixir (2 mg. per 5 cc.)

Robins

A. H. ROBINS CO., INC., Richmond 20, Virginia. Ethical Pharmaceuticals of Merit Since 1878

Dimetane®

(PARABROMDYLAMINE MALEATE)

*Typical Allergens: Animal Hair and Dander • Pollen • Molds • Bacteria and Viruses • Feathers • Insect Scales • Vegetable Fibers and Seeds • Plant Juices House Dust • Drugs and Chemicals • Minerals and Metals

Tourist class (or "coach"): Seats are 39 inches apart. Hot food and alcoholic drinks are served. Cost: $315 (formerly $290).

First class: Same as tourist, except that the seats are 42 inches apart. Cost: $435 (formerly $400).

First class deluxe: Same as first class, except that there are leg-rests and the seats recline farther. Cost: $485.

G.P.s' Attitude Changing Toward Cancer Patients

In the past, the general practitioner has often approached cancer with a "fatalistic attitude." But today, says Dr. Maurice T. Root of West Hartford, Conn., such pessimism is on the wane, thanks to the "appreciable advances in long-term cures."

The G.P. "no longer faces all terminal metastatic disease with despair . . . There are satisfying possibilities in [its] management," he explains. And he illustrates the point from his own practice.

During a recent year, he saw a total of 1,146 patients and made an original diagnosis of cancer in twelve of them. In all, he treated sixty such cases during the year. "Of these, two were asymptomatic but with a blood picture of leukemia. Two were suffering from well-controlled metastatic disease, and nine were dying. The remaining forty-seven had no evidence of recurrence or metastases . . . Thus, for the general practitioner cancer is not all bad."

'Don't Substitute Drugs,' Hospital Rx-Men Told

When you prescribe a brand-name drug for a hospital patient, does the hospital pharmacist sometimes substitute an apparently equivalent brand? His own professional journal has urged him not to do so without getting your O.K.

"Dispense the brand of drug prescribed on each individual prescription, or contact the physician and obtain his permission each time before another brand of drug is dispensed," says the Bulletin of the American Society of Hospital Pharmacists. It points out that substitution prevents "the exercise of a physician's professional prerogative . . ."

Only case where the bulletin would condone substitution: in an institution where the medical staff has approved "an administrative policy" of accepting brand substitutions for certain drugs.

How Hospitals Determine Radiologists' Pay

There's "a simple rule of thumb" for figuring out how much a hospital should pay its salaried radiologist, hospital people have recent-

ly been advised. Consultant John G. Steinle, writing in Hospital Topics, explains that the total of *all* salaries in that department should come to about 45 per cent of the radiology department's total net income.

The rest of the income should be set aside to cover overhead, cost of materials, space, and equipment, etc. At least 20 per cent, Steinle thinks, should be set aside by the hospital "to supplement charges for room and board."

According to this rule, then, how much would a radiologist be paid? Steinle gives an illustration:

"In a hospital that has a net income from X-ray of $111,000," he says, "approximately $50,000 can be paid in total salaries. Thus, if $19,000 is paid for all salaries except that of the radiologist, $31,000 can be paid to him."

Rising Utility Rates May Boost Your Overhead

If your phone, gas, electricity, and water bills seem bigger than ever this year, don't be surprised. Rates for one or more of the utilities have risen in many states. And they may soon go even higher. A Wall Street Journal survey has revealed the following indications of a nationwide trend:

¶ Bell System phone companies

even if your patient is a

gandy dancer†

†railroad man's term for track section hand

...he'll be back on the track with

FLEXILON*

(FLEXIN® + TYLENOL®)

Low back syndromes... sprains... strains rheumatic pains...

FLEXILON gets them back on the job *fast.*

Each tablet contains:

FLEXIN® Zoxazolamine‡ . . . . . 125 mg.
The most effective oral skeletal muscle relaxant

TYLENOL® Acetaminophen . . . . 300 mg.
The preferred analgesic for painful musculoskeletal disorders

supplied: Tablets, enteric coated, orange, bottles of 50.

‡U.S. Patent Pending *Trade-Mark

McNEIL LABORATORIES, INC · PHILADELPHIA 32, PA.

181C19

have already been granted rate increases in twenty-nine states. Bell and other telephone companies have petitioned for still further hikes.

¶ Water rates have gone up, or seem likely to do so, in municipalities throughout the country.

¶ Electricity and gas suppliers will be adding nearly $100,000,000 to consumers' bills in 1958. And they're asking for further rises that may soon double that amount.

There's one ray of sunshine for doctors in—appropriately—Florida. Two large suppliers of electricity there have been ordered to *cut* customers' bills by about $5,000,000 this year.

Group Clinics Offer a Bargain, M.D. Claims

The best answer to higher hospitalization and insurance costs is group clinic care, according to Dr. J. W. St. Geme of the Moore-White Medical Clinic in Los Angeles: "Our private patients . . . know that we have reduced both their need for hospitalization and the days that they must spend there." The only trouble, he says, is that the insurance carriers won't admit it.

A clinic group that includes a pathologist and a radiologist can match most hospital facilities, Dr. St. Geme points out. But the insurance carriers "have been thoroughly indoctrinated," he declares, "by the propaganda that the practitioner of medicine, unless under the supervision of the hospital,

for vaginal moniliasis, trichomoniasis or both

a new specific **moniliacide** MICOFUR™ brand of nifuroxime is combined with the established specific **trichomonacide** FUROXONE® brand of furazolidone

IMPROVED

TRICOFURON®

VAGINAL SUPPOSITORIES AND POWDER

85% CLINICAL CURES* In 219 patients with either trichomonal vaginitis, monilial vaginitis or both, clinical cures were secured in 187.

71% CULTURAL CURES* 157 patients showed negative culture tests at 3 months' follow-up examinations. Patients reported rapid relief of burning and itching, often within 24 hours.

Simple two-step treatment swiftly brings relief and control of vaginal moniliasis and trichomoniasis.

STEP 1 *Office* administration of TRICOFURON VAGINAL POWDER IMPROVED at least once weekly.

STEP 2 *Home* use of TRICOFURON VAGINAL SUPPOSITORIES IMPROVED by the patient, 1 or 2 daily, including the important menstrual days.

*Combined results of 12 independent clinical investigators. Data available on request.

SUPPOSITORIES: 0.375% Micofur, 0.25% Furoxone.

NEW: Box of 24 bullet-shaped suppositories, each hermetically sealed in green foil; with applicator.

Box of 12 wedge-shaped suppositories without applicator.

POWDER: 0.5% Micofur, 0.1% Furoxone. Plastic insufflator, 15 Gm.

NITROFURANS—a *new* class of antimicrobials—neither antibiotics nor sulfonamides

EATON LABORATORIES, NORWICH, NEW YORK


when you give
broad spectrum antibiotics
to your patients—"... some people
have just a devil of a time
with moniliasis ... as I see it,
the only annoying complication
of broad-spectrum therapy
is moniliasis."*
*Long, P. H. in Long, Kneeland, Y. Jr., and Wortis, S. B.:
Bull. New York Acad. Med. 33:552 (Aug.) 1957.
for a direct strike
at infections
plus protection
against monilial superinfection
the best
broad spectrum
antibiotic to use is
MYST
Tetr

THESE ARE YOUR PATIENTS WHO MAY HAVE "JUST A DEVIL OF A TIME WITH MONILIASIS"

- debilitated patients
- elderly patients
- diabetics
- infants, especially prematures
- those who developed moniliasis on previous broad spectrum therapy
- patients on prolonged and/or high dosage antibiotic therapy
- women, especially when pregnant or diabetic

Mysteclin-V provides you with a dosage form for every clinical need:

	Tetracycline phosphate complex equiv. tetracycline HCl (mg.)	Mycostatin (units)	Packaging
Capsules (per capsule)	250	250,000	Bottles of 16 and 100
Half-Strength Capsules (per capsule)	125	125,000	Bottles of 16 and 100
Suspension (per 5 cc.)	125	125,000	60 cc. bottles
Drops (per cc.—20 drops)	100	100,000	10 cc. dropper bottles

SQUIBB

Squibb Quality – the Priceless Ingredient

TECLIN-V

Tetracycline Phosphate Complex (Sumycin) and Nystatin (Mycostatin)

1. Mysteclin-V contains Sumycin — Squibb Tetracycline Phosphate Complex — for faster, higher initial blood levels . . . for more rapid transport of more tetracycline to the site of the infection.
2. Mysteclin-V contains Mycostatin—the first safe antifungal antibiotic — to protect patients against complicating monilial overgrowth.
3. For practical purposes, Mysteclin-V is sodium-free.

would be a poor risk if he were allowed indiscriminate use of . . . laboratory and radiology departments."

This prejudice is costing them money, Dr. St. Geme goes on: "Many procedures now being done in the hospitals for the convenience of the patient, and at the expense of the insurance carrier, could more readily be done in the offices of the clinic group."

In the Los Angeles area, he reports, two days' occupancy of a ward bed cost the insurer at least $45. Yet hospitalization is usual or mandatory for cystoscopies, bronchograms, gastroscopies, hysterosalpingograms, polypectomies, the closed reduction of fractures, spinal punctures, tonsillectomies, and many other procedures.

"Diagnostic clinic groups with adequate facilities could, if permitted, do these procedures without hospitalization," he concludes. Such groups "offer both the patient and the insurance carrier a bargain that both seem slow to accept."

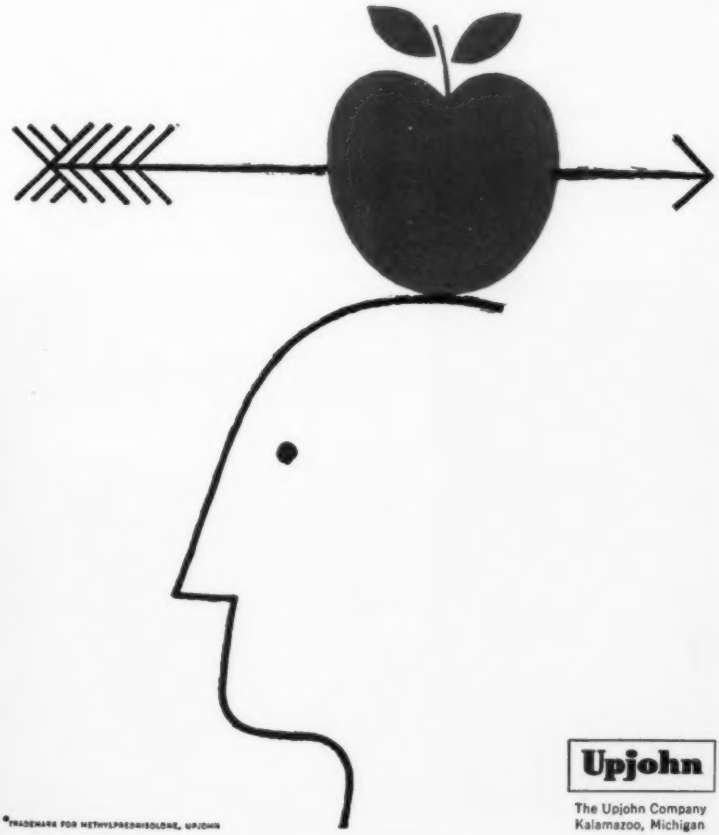
Blue Shield Could Become Panel Medicine, He Says

Should Blue Shield make its coverage available to everyone? Dr. Gilmore M. Sanes of Pittsburgh has his doubts. If such coverage were carried too far, he says, "this

Medrol*

the corticosteroid that hits the disease

but spares the patient



*TRADEMARK FOR METHYLPREDNISOLONE, UPJOHN

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The Upjohn Company
Kalamazoo, Michigan

would ultimately be panel medicine . . . the form of medicine which [doctors] have been fighting."

Blue Shield was established as "a service program for the borderline needy," Dr. Sanes says. It "was not established to compete with the insurance business." But now "many members of the medical profession have become alarmed by the open competition of Blue Shield [for customers whose] health insurance has been successfully handled by the reputable private insurance firms." This looks to him like "encroachment on the domain of the private insurance companies."

As Blue Shield coverage has been extended into middle- and upper-income groups, it "has backfired in many cases," Dr. Sanes concludes.

"The medical profession has even been accused of running a collection agency to further its own ends," he adds.

'Give Psychiatrists Less Medical Training'

Psychiatrists have more important things to learn than medical science, one of the nation's leading sociologists has warned.

"Unless I am grossly mistaken," predicts Harvard's Talcott Parsons, "both the relative importance

of mental illness . . . and the scientific knowledge necessary for its competent handling are destined to grow very greatly in the coming half century." Medicine will be asked to produce more and more psychiatrists. At the same time, it will have to teach them more and more of such subjects as psychology and sociology. In time, Parsons thinks, it will be "out of the question" for medicine to meet both demands and still insist that psychiatrists have "a full orthodox training in general medicine."

"The only solution I can see," says Parsons, "is to train the future psychological physician in general medicine in much more general terms than now, except for some fields very close to his own, like neurology. In other words, the differentiation between psychological and somatic medicine must reach much farther back than now, into the undergraduate years. And psychological medicine must become not just one specialty among others, but probably one of the *two* great primary branches of the profession."

Three-Doctor Collision

A Seattle man recently had an unparalleled chance to demonstrate the principle of free choice of physician. When Otis G. Nordstrom

was injured in a four-car crash, the drivers of the other three cars gathered round, introduced themselves, and offered aid. All three of them, it turned out, were doctors. The injured man looked them over, decided he'd visit his own physician instead.

'Hill-Burton Grants Don't Make a Hospital Public'

When the Hill-Burton Act was new, some medical men feared it spelled loss of autonomy for any hospital that received a grant. "Accept government funds and you'll be declared a public institution subject to government control," critics warned the voluntary hospitals. But now, in a precedent-setting decision, an Arkansas court has ruled that accepting Hill-Burton funds doesn't change a hospital's private status.

"Direct receipt of tax funds by a hospital does not make it a public institution if taxation is not the sole source of revenue," said the court. It refused to order a community hospital to readmit a surgeon dismissed "arbitrarily."

The surgeon had argued that taking Hill-Burton funds made the hospital a public institution. And Arkansas law forbids public hospitals to dismiss doctors without cause. But the court ruled: "A hos-

pital is not a 'public hospital' unless it is founded, owned, managed, and financed by the state and is an instrumentality of the state."

Should Fathers Watch?

If your hospital permits fathers in the delivery room during a baby's birth "local and state laws should be checked" to make sure such sightseeing is legal. So warns Dr. Kenneth Babcock, director of the Joint Commission on Accreditation of Hospitals. Some state laws and local health laws actually forbid the father's presence in the delivery room, he reports. The ban usually encompasses "all other persons not directly or professionally concerned with the delivery."

Blue Shield Plan Pays Doctors' Usual Fees

Are fixed fee schedules an essential element of Blue Shield? An experimental plan in Wisconsin is getting along nicely without them. It's been called "Blue Sky Blue Shield" —not because of any doubts about its financial soundness, but because it provides exceptionally broad coverage with no income ceilings and no fee schedules.

Participating physicians bill the plan according to their own fee standards. As long as the bills seem "reasonable," the plan pays up to a maximum amount for all services combined.

All this began two years ago in

Racine, Wis. Last year the experimental plan was extended to other parts of the state. Today it covers over 25,000 people, who pay premiums about 15 per cent higher than they'd pay for regular Blue Shield coverage.

Some of the new plan's cost figures are now becoming available. Here's what they show for one recent month, compared with the figures for Wisconsin's standard Blue Shield plan:

¶ The average claim under the no-fee-schedule plan was $26.43. Average claim under standard Blue Shield: $32.25. One probable reason for the difference: Many procedures are covered by the new plan when performed at home or in the doctor's office. In such cases, of course, the cost is lower than it would be for in-hospital treatment.

¶ Benefits paid under the no-fee-schedule plan averaged $1.14 per subscriber. Under the standard plan, benefits averaged $1.05 per subscriber.

The close correlation of these figures, plus the fact that premiums for the new plan haven't yet had to be increased, suggests that Blue Sky Blue Shield may be cheaper and more practical than was expected. Also, that doctors *can* be trusted not to abuse a no-fee-schedule arrangement. At least that's the interpretation other Blue Shield plans are drawing.

Iowa, for example, has now decided to offer Blue Sky contracts too. Says an Iowa Blue Shield

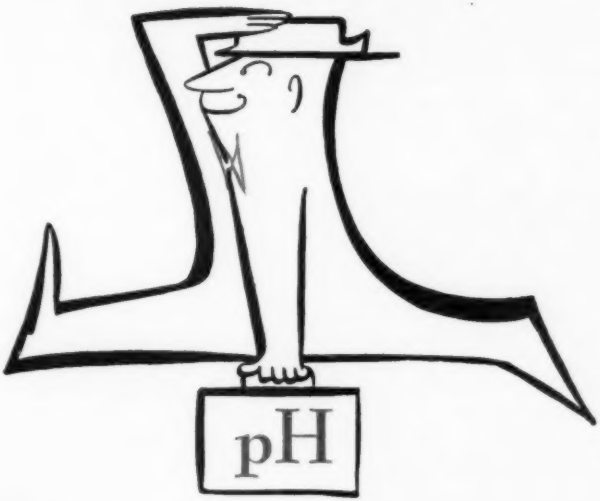
spokesman: "We have gone through the agony of fee-committee meetings too many times, [only] to find that what seemed to be an acceptable level of fees does not prove so in variable situations."

Private Doctors Urged to Seek Safety in Groups

The private practice of medicine is being undermined by the large numbers of physicians who "accept employment that is controlled by a third party," warns Dr. James I. Knott of San Diego, Calif. He sees only one way for private practitioners to survive in the face of such competition from third-party medicine: Let them band together in medical groups.

"The group is stronger than the individual, politically and financially," he explains. "Groups enjoy tax advantages, retirement schemes, legal advice that is difficult or expensive for the individual. They can also afford smart business managers who know how to save money."

Furthermore, Dr. Knott adds, near-universal group practice would "make it possible to give the entire annual crop of new [doctors] a taste of private practice under preceptorship." This, he believes, would help capable but inexperienced young physicians to



Bernie BepHan* says,
"Now my burning belly is O.K.;
BepHan helps me on the way."

Each tablet contains: Bellafoline® 0.5 mg., Aluminum Hydroxide — Glycine 450 mg., Magnesium Oxide 60 mg.
Dose: One BepHan Spacetab® chewed morning and evening.

*T. M. Applied for

SANDOZ

avoid the trap of third-party control.

"Only the indolent and the rejects should be left to service the lay-controlled medical organizations," he concludes.

New Cars Bad Medicine, This Doctor Claims

Even if your automobile is falling apart at the seams, by all means keep it. New cars just cause trouble says Dr. Loren G. Shroat of Seattle, Wash.

For instance: "When you buy a new car, you advertise the fact that you are prosperous. [Then] all your creditors are after you. You are automatically placed on all the sucker lists: Everyone from the American Legion to the parish priest is out to share your wealth."

Again: "Old cars are safer than new because there is no temptation to speed. You know how fast the old boat will go . . . Nobody expects much of you. You don't have to keep up with the Joneses or try to pass them on a curve."

Old cars save you money, too, Dr. Shroat observes. "You have a small investment, no taxes, and little insurance. You do not need property damage and liability insurance . . . If you run over [one or more] persons while driving an old car, they get up, look at your old

RED CROSS

IMPROVED BANDAGE

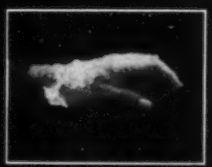
conforming gauze
makes your bandaging easier!

just rolls on ...

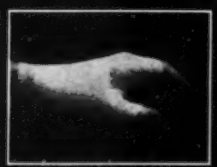
CONFORMS
to any shape.

ADHERES TO ITSELF
—will not slip or slide.

STRETCHES
—will not constrict swelling area.



THE OLD WAY. Ordinary gauze bandage loosens up and frays at edges, and restricts movement of joints.



THE NEW WAY. New Red Cross Improved Bandage stays on smoothly . . . allows more freedom of movement.

No connection whatever with American National Red Cross

Announcing a potent modern tonic containing B_{12}, B_6, iron and folic acid

Vi-Sorbin*

Because it incorporates the newly discovered **Absorption Enhancement Factor,** D-Sorbitol—

'Vi-Sorbin' assures:

Vitamin B_{12} serum levels superior to those obtained with weekly injections of 100 mcg. B_{12}

Enhanced absorption of **iron**

Rapid and efficient **hematopoiesis**

Measurable as well as **subjective** results in your "tonic patients"—particularly the adolescent, convalescent, pregnant and geriatric.

Available: In 8 fl. oz. bottles, specially treated to avoid damage to 'Vi-Sorbin' from light.

*Trademark

How the revolutionary new Absorption Enhancement Factor was discovered

While conducting a long-range study of Vitamin B_{12} serum levels in several groups of patients, Chow of The Johns Hopkins University found that one group consistently showed surprisingly high B_{12} levels. Investigation revealed that these patients were receiving an experimental oral vitamin preparation made by Smith Kline & French.

After many months of investigation, the factor responsible for the enhanced B_{12} absorption was identified. It was found to be D-Sorbitol—an agent that had been included in the formulation as a sweetener and pharmaceutical stabilizer.

Further investigation brought forth a discovery of equal, or perhaps even greater, significance: this **Absorption Enhancement Factor** produced its effect not only on B_{12}, but also on iron.

Smith Kline & French Laboratories,
Philadelphia

heap, and dust themselves off: Then they limp down the street and you never hear from them again."

Most important of all, an old car jiggles and squeaks. "When you are driving," Dr. Shroat points out, "you know that you are riding. There is no chance that you will think you are home on the davenport and wake up in the hospital or playing a harp."

German Medicine May Be Partly Desocialized

West Germany's national health insurance program is in trouble because of overuse. Its reserve funds are used up, and it's going into debt. The recent flu epidemic helped bring all this about, says an official bulletin of the West German Government, reporting "a flood of medical certificates and a ruinous waste of medicine."

Between 25 and 27 per cent of workers' wages are already being withheld for pension, health, and family allowance schemes. Almost half the amounts withheld go for health insurance. German politicians are reluctant to meet the crisis by increasing contributions still further.

The solution, they think, may be partial desocialization. It's proposed that West Germans now pay

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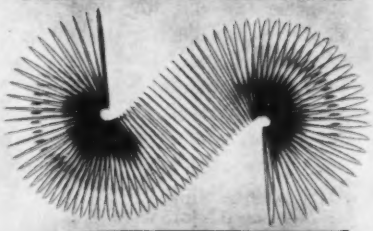
quick stop to g.i. spasm...



no atropine or belladonna-like side effects...[1,2]
safe—even in the presence of glaucoma[3-5]

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their own small medical bills, leaving the health fund to pay big bills only. It's also proposed that bonuses be paid to people who have filed no claims for a certain period —say, twelve months.

Chiropractors Join Union

What's in it for the chiropractors? That's what some physicians wondered recently when chiropractors of two California counties affiliated with the A.F.L.-C.I.O. Explained A. G. Lockwood, temporary president of the Chiropractic Professional Union of Riverside and San Bernardino Counties: "Most of our patients are working people. By joining the A.F.L.-C.I.O., we can . . . help with their union health and welfare funds."

U. S. General Practice Seen as Un-English

Is the American system of general practice pretty good? At least one Britisher appears to have his doubts. Says a writer in the British Medical Journal:

"In the U.S.A., the general practitioner has fewer patients [than his English counterpart. Such patients] are often of the 'floating' type, with little permanent loyalty to any one doctor, seeking advice from different practitioners de-

pending on the afflicting disease... The American practitioner is expected by the patient to undertake a wider range of treatment...[e.g.,] surgical procedures, radiological examinations, and electrocardiography. Whether this is a good system or not is a matter of opinion."

Humorist Improves on the A.M.A. Consent Forms

A.M.A. legal experts have been busy promoting a new set of consent forms that spell out in detail the hazards a patient may face.* But the lawyers have "undershot the mark," observes Dr. Justin Dorgeloh. The West Coast pathologist thinks a really "comprehensive caveat emptor" would go much further.

With tongue well in cheek, Dr. Dorgeloh has written out several sample consent forms of his own. His "Consent to Operation," for example, has the patient agree not only to the usual procedures, but also "to any additional necessary procedures short of total evisceration." The Dorgeloh-designed form continues:

"I fully understand that ligatures occasionally have an annoying tendency to wriggle off blood vessels, thereby possibly leading to copious postoperative hemorrhage. It furthermore has been explained to me that such hemorrhage can easily result in profound shock . . .

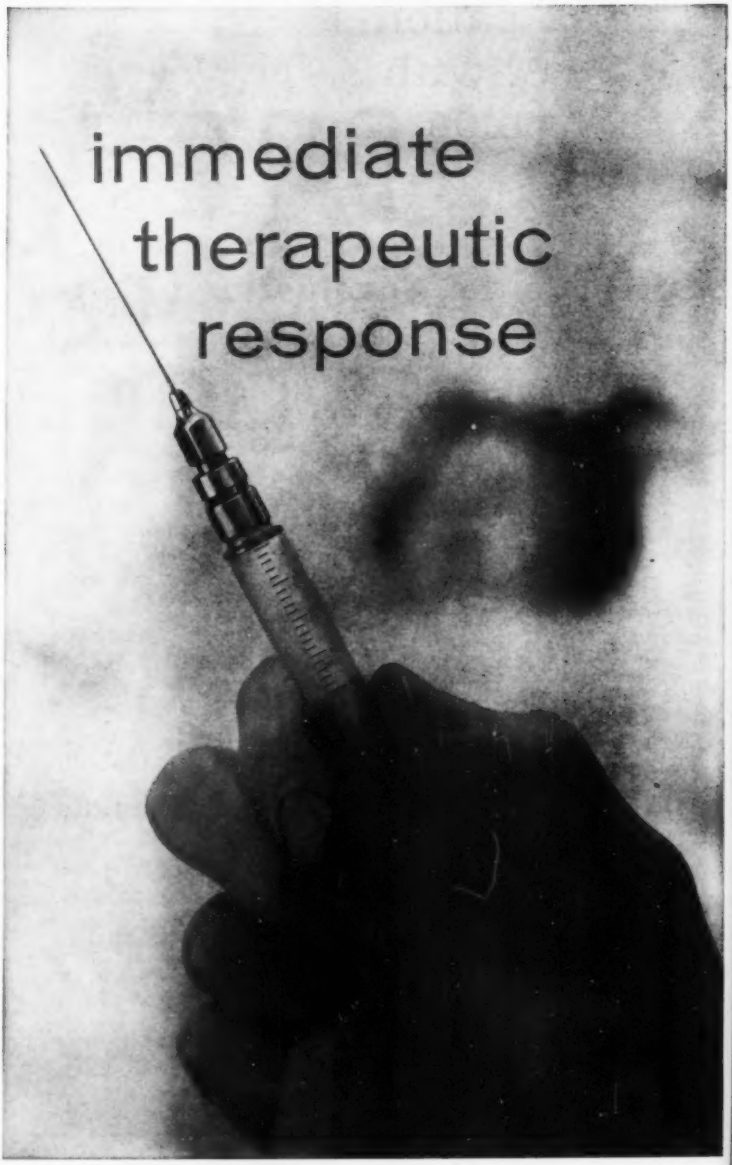
"The possibility of postoperative infection has been pointed out to me, and the chances of alarming side-effects from any antibiotics used to combat such infection. Hives, sore anus, membranous anterocolitis, or anaphylactic shock will come as no surprise . . ."

Besides wanting the present forms to be more specific, Dr. Dorgeloh feels new forms should be introduced. Thus he offers a "Consent for Blood Count." Here the patient attests that he realizes "there is no warranty that the needle prick will not lead to infection. I furthermore realize that cure of said possible infection is not guaranteed."

Then there's a "Consent for Soap Suds Enema." This one has the patient attest: "I fully realize that, should I by chance happen to be suffering from near-perforation of the colon due to acute diverticulitis, an enema could well prove disastrous. I herewith declare that I am not now, nor have I ever been, a victim of acute diverticulitis. I furthermore attest that I am not allergic to soap."

Of course, Dr. Dorgeloh notes, "some patients are unduly impressionable." So he has worked out what he calls "the most important consent form of all: 'Permission to Administer Large Doses of Tranquilizing Drugs.' " END

*See "New Legal Forms Guard You From Suit," MEDICAL ECONOMICS, October, 1957.


immediate
therapeutic
response

respiratory infections
gastrointestinal infections
genitourinary infections
miscellaneous infections
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250 mg. per 1 dose vial
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Each vial contains tetracycline phosphate complex equivalent to 250 mg., or 100 mg., of tetracycline HCl, with 2% Xylocaine. (Note: 250 mg. dose may produce more local discomfort than the 100 mg. dose.)

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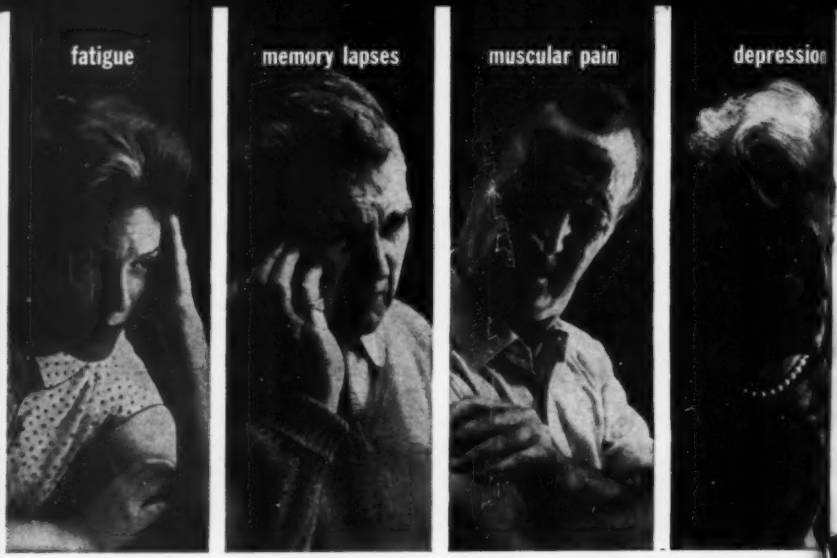

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Plestran is indicated as an aid in restoration of vigor in middle-aged or elderly patients who complain of chronic fatigue... reduced vitality... low physical reserve . . . impaired work capacity . . . depression . . . muscular aches and pains . . . or cold intolerance. Such "signs of aging," far from being due to physiologic disturbances, may often result from endocrine imbalance, especially gonadal and thyroid dysfunction.[1-4] Plestran provides ethinyl estradiol (0.005 mg.); methyltestosterone (2.5 mg.), and Proloid®* (¼ gr.)—hormones which help to correct endocrine imbalance and often halt or reverse involutional and degenerative changes.[1-4]

Plestran restores work capacity and a sense of well-being, usually within 7 to 10 days. It improves nitrogen balance, leads to better muscle tone and vigor, enhances mental alertness, helps to correct osteoporosis, senile skin and hair texture changes and relieves muscular pain.

The anabolic and tonic effects of the hormones in Plestran appear to be enhanced by combination so that small dosages are very effective. Combination also overcomes some of the disadvantages of therapy with a single sex hormone, such as virilization, feminization or withdrawal bleeding.[5]

Dosage: Usually one tablet daily; occasional patients may require two tablets daily, depending on clinical response.

Supplied in bottles of 100 and 500.

*Purified thyroid globulin

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100 YEARS OF SERVICE TO THE MEDICAL PROFESSION

Medical Economics

INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS, MAR. 31, 1958

Fruitless debate about whether there's a shortage of doctors today has been laid aside. The problem now is: Will there be enough doctors for tomorrow? Or will growing U. S. needs mean you'll have to stretch out your sixty-hour work-week still further?

CRISIS *In the Supply of Doctors*

By Lois R. Chevalier

"The greatest danger I see in the future is not the H bomb. It's the P bomb—P for population. I don't have the wisdom to determine how we can avoid the inevitable chaos of China, India, and other areas where the P bomb has destroyed any semblance of moral or scientific progress."

With these words, quoted from a colleague, Dr. Julian P. Price, A.M.A. trustee, opened a panel session of the Congress on Medical Education and Licensure last month in Chicago.

Such congresses in the past have often brought forth a lot of theorizing on pedagogical problems. This time the deans, professors, and licensing authorities looked up from their texts and tests to focus on the future. What's more, they invited in an impressive list of outsiders to

consider medicine's needs for 1975. Leaders of industry and labor, university presidents and congressmen, doctors of sociology, economics, and demography took part—along with hospital spokesmen, insurance executives, and foundation officers.

One major conclusion emerged so clearly and solidly that it dominated the discussions. It was this:

Shortage Ahead

American medical schools are working toward a peak production of 7,400 graduates a year. But by 1962 we'll need more than that just to keep pace with population growth. By 1975 we'll need at least 9,400 new doctors a year. And if a wealthier, better-educated population wants *more* medical service than people get now, even 9,400 new doctors a year won't satisfy public demand.

It's obvious what this may mean to doctors now in practice. If you're typical of them, you presently work sixty hours a week. But if the experts' estimates prove valid, you'll have to anticipate working sixty-five or seventy or even seventy-five hours a week before too long. You will, that is, unless the supply of new doctors is somehow stepped up beyond anything now contemplated.

The medical men and their invited experts reminded themselves repeatedly that all such figuring has to be highly tentative. But in a sea of variables, one figure stood like a rock:

There'll be at least 50,000,000 more Americans by 1975. Demographer Dudley Kirk of the Population Council said this was a conservative estimate. It assumes no drop in the death ra between now and 1975. It recognizes that for a while there'll be fewer young adults to reproduce because that age group dates back to the low-birth-rate depression years. Even so, we're going to add enough people to populate the Detroit metropolitan area *every single year.*

We Haven't Lost Yet

Right now our medical schools are keeping pace. They've stepped up their annual output from 6,000 to 6,800 in the last five years alone. New facilities now in prospect will push the figure to 7,400 by 1962.

After that, says a recent official fact sheet put out by the

A.M.A., the number of "annual graduates from presently approved medical schools and those in development will level off." At the same time, "the population will continue to rise sharply."

Is there any possibility that this soaring population will be satisfied with relatively fewer doctors than today? A few signs point that way. Biggest influence in this direction: the doctor's increasing efficiency.

Thanks to medical advances, better equipment, better transportation, and better use of ancillary personnel, "one physician today may properly care for twice as many patients as his predecessor did twenty-five years ago." So said Dr. W. Clarke Wescoe, dean of the University of Kansas Medical School during last month's meeting in Chicago. Patient loads may properly "become even higher in the future," he added.

But increasing individual efficiency can be carried just so far. As Dr. Ward Darley, executive director of the Association

"That's the second operating-table top this month, Higgins. You simply *must* learn not to bear down so hard on your scalpel."

of American Medical Colleges, put it: "You can carry efficiency to the point where medicine loses its effectiveness. The doctor has to know his patients well enough to let his own personality be a therapeutic weapon. That kind of relationship takes time."

More Time Per Case

Patient care tomorrow may even take *more* of the doctor's time per case, several of the experts warned. Dudley Kirk pointed out that past "spectacular successes in conquering epidemic disease were relatively cheap in terms of medical service." They resulted from things like inoculations and antibiotics—things that didn't take much of the doctor's time. But the new emphasis on "the treatment of chronic and mental illness would seem to require more intensive medical service per unit of population."

Two other key factors also point toward the need for *more* doctors in relation to population —not fewer:

1. The nation's growing purchasing power. As Dr. Kirk put it: We're becoming a nation of skilled workers and managers. And "this upgrading . . . means an increasing demand for medical service . . . increasing awareness of the value of medical care and increasing ability to purchase it."

2. The U.S. political trend. Harvard Sociologist Talcott Parsons said: "I would expeet it to become increasingly a matter of public policy to assure rather high minima of access to health care to the whole population, independent of the financial resources of the family . . ."

So there you have the key factors. Next question: How do you apply them to tomorrow's doctor needs?

A Method of Planning

Nobody at the Chicago meeting managed to work out an exact equation. But the assembled experts did come up with a rule of thumb for planning future physician needs. What's more, it seemed to satisfy most of the doctors present.

Here's the way it happened:

In a closed session chaired by Dr. John Cline, former A.M.A. president, twenty topflight men began talking about the difference between *demand* for medical services and *need* for medical services. They defined "de-

mand" as the amount of medical care people ask for without prodding and can afford to pay for. "Need," they said, is the amount of medical care (preventive as well as curative) necessary to provide optimal health.

Demand, they said, has been in pretty good equilibrium with supply over the years. As for need, no one knows.

Perhaps need could be measured. A sample of the population could be examined, and the difference between their demands and their needs could be determined. But the experts conceded that such a study would take time —and that it takes as much as fourteen years for a new medical school to begin turning out doctors.

Down to Brass Tacks

That's when Dr. Cline asked what they thought should be done about doctors for 1975.

He looked around at the group, which included Dr. Aims McGuinness, the Government's No. 1 physician; C. Manton Eddy, vice president of the Connecticut General Life Insurance Company; Clifford M. Hardin, chancellor of the University of Nebraska; and James Brindle, director of the United Auto Workers' social security department. Asked Dr. Cline:

"Is the physician-population ratio which has existed for the past fifty years a reasonable basis on which to estimate the need for physicians in the future? I know you can give me only an educated guess, but there will seldom be a chance to get a guess from such a collection of experts as the group around this table."

We Can't Have Less

Only two of the twenty believed anything less than the present doctor-population ratio would be satisfactory.

So the group reported: "Although the physician-population ratio may not be the best measure for future planning for medical care, it is the best measure which can be brought to bear on the problem at this time . . . It would be prudent to pursue that ratio in planning for the production of physicians over the next several years."

Will Laissez-Faire Do?

Up to now, the ratio has taken care of itself, Dr. Leland McKittrick, chairman of the A.M.A. Council on Medical Education

and Hospitals, pointed out. In 1920 there were 137 physicians for every 100,000 people in the U.S. In 1950 the ratio was strikingly similar: 135 physicians for every 100,000 people.

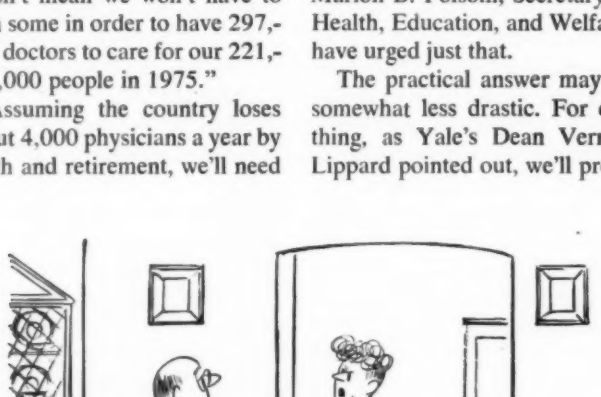
"It's come out that way without a great deal of planning," said Dr. McKittrick. "But that doesn't mean we won't have to plan some in order to have 297,000 doctors to care for our 221,000,000 people in 1975."

Assuming the country loses about 4,000 physicians a year by death and retirement, we'll need 9,400 new M.D.s a year by 1975 just to hold the ratio steady. That's 2,000 more than we're set up for now.

How can we turn out that many additional doctors?

One drastic answer is: Build twenty new medical schools! And some leaders, including Marion B. Folsom, Secretary of Health, Education, and Welfare, have urged just that.

The practical answer may be somewhat less drastic. For one thing, as Yale's Dean Vernon Lippard pointed out, we'll prob-



"... So I promised that *you* would teach the Brownies first aid ..."

ably continue to depend on foreign medical graduates to supplement the output of our own medical schools. We're now licensing about 1,000 foreign graduates a year, compared to 300 in 1950. Not all of them are —or will be—foreign-born doctors. Right now there are 1,800 U.S. citizens studying medicine abroad.

Another answer may be to speed up our present production lines. Johns Hopkins has led the way by adding eight weeks to the academic year. If other medical schools ran forty weeks a year instead of thirty-two, we could pick up an extra class of graduates every few years.

Enlarge Classes?

Larger classes are also possible, though medical educators feel that high quality of teaching is tied in with a low ratio of students to teachers. Present graduating classes average about 100 students. If some of the average-size classes could be stepped up to something like the 186 graduates the University of Michigan turns out, tomorrow's doctor supply would begin to approach adequacy.

Still another approach is to start more two-year schools. "If initiated in a sound university environment," says a recent statement of the A.A.M.C., "some of these new schools eventually would evolve into first-rate four-year schools of medicine."

Seedbed Technique

Meanwhile, they'd be feeding graduates into the junior classes of established four-year schools —which can accommodate 300 to 400 more late entrants, the A.A.M.C. says. Some of these openings are due to flunk-outs and drop-outs. Others reflect "the ability of some schools with big teaching hospitals to accommodate more clinical than preclinical students."

Can a deficit of 2,000 doctors a year be overcome by these various expedients? And will the present doctor-patient ratio be good enough in 1975? Your guess is probably as good as the experts' on these points.

How It Affects You

But you have an even stronger stake in seeking the best answers. Because to whatever extent the country's medical needs are underestimated, *you* are bound to be overworked. END

Tax Savings You're Likely to Overlook

By Joseph F. McElligott

Want to cut your Federal income tax bill by $300 to $500? It can usually be done if you're careful to deduct the dozens of little professional expenses many doctors forget about.

Ninety-nine per cent of such legitimate deductions are overlooked for one reason only: Instead of using checks and charge accounts even for minor expenses, the doctor thoughtlessly dribbles out cash. So he has no record of such outlays—nor any recollection of them on April 15th.

Today's doctor might well take a cue from today's business executive in this respect. As one tax-conscious businessman told me recently: "I never reach for cash any more unless it's a hold-up!"

Try giving yourself a "wallet test" right now. Take out your billfold and look inside. If you're as tax-savvy as you ought to be, you'll find in it a gasoline credit card, a telephone credit card, a dining-club credit card, a rail-

THE AUTHOR *is a tax and medical management consultant in New York City. He formerly worked for the Government as an Internal Revenue agent.*

They're small items, some of them. But they can add up to big tax deductions if you maintain a running record of them. Here's how

air-automobile credit card, and some blank checks. Cash too? Sure. But only a small amount.

If you don't have all the above charge-account equipment, I suggest you get it now. It'll save you money on your tax return for 1958.

Meanwhile, what about your tax return for 1957?

Chances are that you sprinkled unrecorded cash all over the landscape last year. Better check carefully through the following list of eleven deductible items most commonly neglected by doctors. The Treasury Department isn't likely to challenge conservative estimates of such expenditures if your major expense records are in first-class shape.

1. Practice-connected transportation costs. I know doctors who've raised their deductions by hundreds of dollars as the result of setting up a simple recording system for automobile operating costs.

First, they've arranged to have their cars serviced at service stations where they maintain complete charge accounts. Secondly, they carry gasoline credit cards for use elsewhere.

This automatically gives them a written record of ma-

jor expense items. But three seemingly minor items call for a different approach:

¶ Parking charges. Many a doctor without parking facilities at his downtown office leaves his car at a corner lot and hands the attendant 50 cents a day. In a year, he may pay out over $100 in parking charges—all of it deductible if he thinks of it. Better system: Have your parking-lot bill sent to the office monthly so you can pay it by check.

What if you regularly have to pop small change into a parking meter? Here's an easy way to keep track of the total: Install an automobile coin dispenser that holds $5 in coins. Use it for all your meter money. Whenever you fill the dispenser, make

"I've got a funny feeling he's from Internal Revenue and is checking the O.R. schedule."

a record of it for your tax files.

¶ Emergency car costs. Even if you have a charge account at your local service station, you'll run into special situations requiring cash outlays. Last December, a client of mine was out on house calls when a heavy snowstorm set in. He stopped at the first handy garage and paid out $85 for a pair of snow tires. After a month or two, he completely forgot about this necessary business expense—until he was reminded of it just recently by a chance remark. Better system: Be sure to get a receipt for all such major outlays.

Don't Forget Cabs

¶ Taxi fares and highway and bridge tolls. Some cab drivers will issue a receipt on request. Tolls can be paid out of a car coin dispenser. If you buy a book of toll tickets, the empty book will serve as a receipt. However you do it, don't fail to remind yourself of such steadily snowballing outlays. They can mount up into the hundreds of dollars faster than you think.

2. Postage and office supplies. If you send out 500 bills a month, you're spending $180 a year on postage stamps for this purpose alone. Does some of the money come out of your own wallet—when, for example, your aide needs to replenish the petty cash box? Before filing your tax return, check back to see that you've fully deducted for such things.

Suppose your printing bill shows that about 6,000 statements were used last year. Suppose your check stubs and petty cash records account for the purchase of only 4,000 stamps. You probably reached into your pocket for an additional $60 of stamp money.

Better system: Replenish your petty cash fund periodically by check. The tax-wise doctor gives his girl a monthly $50 or $100 check made out to cash. He insists she keep a strict written account of all disbursements. And he instructs her never to ask him for cash to cover an office expense.

Business Calls at Home

3. Business phone calls hidden in your household account. A busy practitioner can overlook upwards of $100 a year in deductible phone charges, if he fails to allow for the professional calls he makes from his home. It's dif-

ficult to segregate personal and business calls with complete accuracy. But the following rule of thumb should help:

Write off as a professional expense everything above the basic monthly charge for your home phone (excluding personal long-distance calls, of course). For example, if the basic charge is $6.50 and your monthly bill runs to $20, you can usually consider $13 as a practice-connected expense without much risk of being wrong.

What if you make frequent calls from pay phones or from patients' homes? A telephone credit card will permit you to have all such calls charged to your office phone bill.

4. Incidental convention expenses. Even cost-conscious doctors slip up on this item because of the pressure of convention activities. And slip-ups are costly: At a three- or four-day convention, you can easily drop $100 in cash on incidental expenses like taxi fares, registration fees, new medical books, dinner and drinks for other physicians, etc. To keep your accounts straight, I suggest you paste these two rules in your convention-going book:

¶ Put everything possible on your hotel bill. Most hotels will let you charge anything from morning papers to after-dinner cigars. Then be sure to pay your bill by check.

¶ Use a dining-club credit card when away from the hotel. If you do any professional entertaining anywhere, such a card enables you to charge meals, theatre tickets, rented cars, even flowers. You get monthly bills, and you pay them by check. Thus you automatically accumulate a complete written record of such expenditures.

Small Donations

5. Small charitable contributions. Many a doctor could deduct an extra $200 or so on his tax return if he took all his minor contributions into account. Since the money trickles out in coins and small bills, it's almost impossible to keep a strict record of it. But you can make a fair estimate.

For example, if you and your wife each put $1 a week in the church collection plate, that's over $100 a year. If your four children contribute a quarter apiece each week at Sunday School, you've got another $50 in deductible donations. And what about the dollars' worth of

stuff you give to cake sales, church bazaars, Boy Scouts, etc.?

Get your wife to help you tot up such small donations. Between the two of you, you may well arrive at a justifiable figure of $200 to $300. And if you have canceled checks to support deductions for major contributions, your carefully-thought-out estimates on minor items aren't likely to be questioned.

6. Business entertaining at home. Naturally, you keep a cost record when you give a big party for twenty of your colleagues. But what about more casual home entertaining? When three or four local doctors drop over to discuss some medical matter, the evening may cost you a $10 bottle of Scotch and a $5 ham. Unless you're tax-conscious, you probably pay no attention to such little things. But they can add up.

Best system: Put your wife in charge of the bookkeeping. Give her a notebook in which she'll record names of guests and all expenses incurred in business entertaining. She can include costs of food, drinks, flowers, linen laundering, domestic help, phone calls, etc. The day after a party that's clearly practice-connected, ask her to bill you for the amount she's spent. Then hand her a check to cover it. Be sure to file her bill with your tax records.

7. Business gifts. How did you handle your Christmas buying last year? There's a wrong way and right way to purchase practice-connected gifts.

The wrong way: Shop all over town, pay cash, come into the hospital on Christmas Eve loaded down with packages. You have no record of what you spent; and you've used up a lot of valuable time and energy as well as dollars.

The right way: Buy everything in a single department store where you have a charge account. The store delivers the gifts to your employes, associates, colleagues, etc.; and you have an itemized record for your files.

Bad Investments

8. Losses incurred on worthless securities. Let's suppose you once took a $500 flier on a uranium promotion. The company never did get a Geiger counter clicking. Last year it threw in the sponge officially.

You now have a $500 tax-deductible loss. But the full amount must be claimed on your tax return for 1957. Unless you claim

such a loss for the tax year when the securities actually became worthless, the deduction is legally gone forever.

So check up right now on any dubious investments. If you're not sure whether a given issue is officially worthless, ask your broker to get you the facts before April 15th.

9. Payments for occasional office-maintenance services. Do you pay cash for the cleaning woman, the laundryman, the electrician who installs a new light switch, and the boy who shovels snow off your sidewalk? Such persons generally prefer cash. But you'll be sure to deduct all you're entitled to only if you make it a rule to pay them by check.

Better think back over the list of maintenance people who did some work for you last year. Recall any unrecorded payments? They can mean money in your pocket now.

Checking Accounts, Etc.

10. Bank charges. This may not be the small item you probably think it is. Your bank charges can run between $50 and $100 a year. You're likely to lose sight of them because they're deducted directly from your bank balance.

Such tax-deductible items include monthly carrying charges on checking accounts, penalty fees for stop-payment orders, etc. And don't forget to add the rental you pay on a safe-deposit box in which you keep income-producing securities.

Stationery Items

11. Money paid out in impulse-buying. Just recently, a doctor I know went into a stationery store to buy anniversary cards for two colleagues. He came out with these additional purchases: a desk calendar, a copy of "Arthritis and Common Sense," and a gadget to screen out background noise on the phone. These items killed a $20 bill. All were practice-connected purchases. But he never thought to record them as a business deduction.

Examine your own buying habits. Remember that modern advertising tends to produce impulse-buying. If you really want something related to your practice, by all means go ahead and buy it. But don't pay cash. Write a check instead—and watch your tax bill shrink. END

Is the Right Man Covering for You?

This doctor thought he'd left his practice in good hands—until he came back and some of his patients didn't. Here's his solution

By Werner Bergmann, M.D.

A headache that lasts for a day or two can be bad. One that lasts for 365 days every year had better be cured —or else. The permanent cephalalgia that afflicts many of us doctors is brought on by the following conflict: Our patients want us to be around all the time; but we ourselves would like an occasional few hours, or even a few days, to ourselves.

After suffering from this headache for years, I finally decided to cure it. So, not long ago, I began looking for

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THIS ARTICLE *has won one of the 1957* MEDICAL ECONOMICS *Awards for its author, a G.P. in Oakland, Calif.*

a physician who'd cover for me whenever I felt I needed a brief session on the porch swing or golf course.

It Wasn't Easy

Sounds simple, doesn't it? But I soon learned that the cure can be more agonizing than the headache. Let me tell you about it:

It seemed to me that the best way to find the man I wanted was to listen in on some staff-room gossip. That's how I started my search. Whenever I heard of a struggling young fellow trying to build up a local practice, I marked down his name in a small black book (courtesy of a drug company that manufactures tranquilizers).

The First Prospect

Finally I got up my courage and phoned one such man. His name was Henry Janson; and he was a young G.P. with an office only a few blocks from mine. I had trouble getting through to him. The woman who answered his phone wasn't sure where he was. After five minutes of holding the line and waiting, I left my name and hung up.

Some hours later, just before quitting time, the doctor returned my call. "This is Dr. Janson," said a polite, cultured voice. "What can I do for you?"

"Well," I said, "I hear you're new in town and not too busy. How about covering for me during my vacation and a few weekends? I want to go away next week, for example. Could you take my house calls?"

'I'm Rather Busy'

The cultured voice became hesitant. "I'd love to, Doctor. But—well, I *am* rather busy. There's the blood bank and my work for the well-baby clinic. Then, too, I'm working for an insurance company and trying to build up my own practice. I just don't know. Can I call you late next week and let you know?"

"I'm afraid not, Doctor," I said. "That's when I take off. Thanks anyway."

"You're entirely welcome . . . By the way, I hear you don't do any surgery. Now, I had two years of training at Massachusetts General. If you ever feel like steering one of your surgical cases my way, I'd sure appreciate it."

The next name in my black book was that of Fred Dickers. An internist-friend had recom-

mended him highly: "You'll find Fred most cooperative. He's a go-getter!"

So I called Fred. "This is Dr. Bergmann," I began. "Dr. Archield tells me you might care to cover for me during my vacation and maybe later on for weekends and occasional evenings."

"Sure," he answered heartily. "Let's have lunch and discuss it further."

At our luncheon meeting, everything went well. Young Dr. Dickers told me he'd recently moved to our town after practicing for two years in the Middle West. "I'm still not earning quite enough to live on comfortably," he explained. "So your offer is just what the doctor ordered. I hear you have a heavy practice. Is that true?"

"I think so, Fred," I said. "Anyway, you should see at least twenty people while I'm gone next week. I'll tell my girl to send you everyone she can't take care of herself."

A Vacation at Last!

I left the following week for a much-needed vacation. When I returned, my aide told me she thought Dr. Dickers was a wonderful man. "Whenever I wanted some help with a patient, he was right there," she said. "He was truly a joy to work with."

"That's fine," I replied. "Looks like I've found the cure to my eternal headache."

He Didn't Phone

I waited for Fred Dickers to call me, but he didn't. A couple of days later, I called him. "Thanks for covering me," I said. "Did you see any patients?"

"Wait just a minute while I look at my list," he answered. Then: "Here it is. Yes, I saw seven people. Nothing important—some sore throats, a gal with acute bronchitis, the usual. Sorry I didn't call you, but I was busy. Fact is, my own practice seems to be booming. I have to run now."

A week later, John Lindstrom, one of my regular patients, phoned me. "Can't you do something about your Dr. Dickers?" he asked in a strained voice.

"Do what, John?" I said, in puzzlement.

"Stop him from bothering me. While you were on your vacation, I saw him once for a sore throat. He gave me a few shots of penicillin and took some throat cultures. After a few days I felt

fine. So why does he call me every other day or so to ask when I'm going to see him for a complete check-up? I thought I was *your* patient."

"Sorry, John," I said. "There must be some misunderstanding. Leave it to me."

It Wasn't Just One

When two more patients told me an almost identical story, my headache came throbbing back. So I decided to ask my personal physician (an old and very wise bird) to help me find a cure.

"Werner," he said, "you should know that your problem's a mean one to solve. Of course, you *could* go on using a fellow like Dickers, if you're willing to wink at some innocent patient-stealing. But my guess is that you won't.

"Or you could exchange with another man as busy as you. But such men usually work in small groups—which leaves you at a disadvantage as a soloist.

"Or you could leave it up to the medical society exchange to find someone for you. That way, you might lose your headache and gain a lawsuit for deserting patients."

He shook his head. "I wouldn't prescribe any of those things," he said. "What I suggest is that you hire yourself a man. Go to the county hospital, speak to some of the residents there, and see whether you can arrange something."

It turned out he was right as rain. I followed his advice to the letter. And now Dr. Lorenz, a resident in internal medicine, covers for me at $10 an evening —or at equivalent rates for other periods of time. I'm not getting all the time off I wish I could. But for forty to fifty dollars a month, I do get four or five entire evenings to myself.

Happy Ending

My patients are happy, because they receive immediate attention. I'm happy, because I can profit from the opinions of a young man trained in the newest scientific methods. And my covering doctor is happy, because he's earning an extra few dollars. Not only does he get what I pay him, but he can also charge my patients a regular fee for a house call.

It's a good deal all around. I recommend it to others who've been suffering from my particular kind of headache. END

Forecast for Physicians: More Work, Less Money

A special assistant to President Eisenhower looks into the doctors' future—and sees increased efficiency but not increased pay

Medical practice tomorrow is bound to be more institutionalized than it is today. That means it will also be more impersonal and less lucrative. These changes are "more imminent than the profession realizes," according to Meyer Kestnbaum.

Mr. Kestnbaum is a businessman—head of Hart Schaffner & Marx. He's also a special assistant to President Eisenhower for implementing the Hoover Commission recommendations. In both capacities, he's had more opportunity than most men to observe developing trends, and to see what these trends portend for the future. Here's what he sees for doctors:

"Population increases and a growing demand for superior medical care will put a strain on the profession far beyond anything contemplated at this time. This will make it impossible for doctors in the future to give everyone individualized service—the kind where the physician knows his patient intimately. Some institutionalization of medicine is inevitable.

"There will be serious pressures for socialization of

more of our medical resources. There will also be serious pressures on medicine to make better use of its personnel. Medicine is clinging to nineteenth century concepts of organization and economy, while industry has moved on to the twentieth century. In the future, doctors will have to concentrate on improving their efficiency.

"The society of the future will certainly demand more efficiency from doctors, but it probably won't pay them more. Institutionalization alone will make it harder for the average physician to build the kind of lucrative practice many have today. There won't be as many doctors among the really wealthy men in the community." END

Blood Will Tell

When I was a pathology resident some years ago, one of my many chores was to help keep the hospital's blood bank well supplied.

One of our steady sources of blood was a penitentiary just outside of town. Periodically a team of us would go there to draw blood from volunteers among the inmates. And we discovered an interesting thing clinically about these donors: The incidence of Rh negativity among them was about 25 per cent—definitely higher than that found in the general population.

So we began to speculate about a possible relationship between Rh negativity and criminality. One colleague was particularly fascinated by this possibility. He announced he intended to write a paper on our findings. Soon he seemed able to talk of little else. In fact, he got to be a bit of a bore.

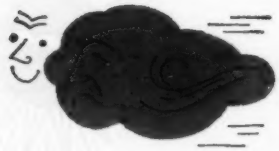
Suddenly, though, he seemed to lose interest in pursuing the subject.

That was the day he found *his* blood was Rh negative..

—H. MOSE, M.D.

For each previously unpublished anecdote accepted, MEDICAL ECONOMICS *pays $25 to $40. Address: Anecdotes, Medical Economics, Inc., Oradell, N.J.*

How Much Should



You Varnish the Truth?

'Medical pessimism pays,' one doctor said. 'Patients like optimism better,' said another. Here's how the ten-doctor discussion came out

By John A. Ewing, M.D.

During a recent county medical society dinner, the conversation at our table was pretty ordinary until Dr. Brand, a middle-aged G.P., said something that really caught everyone's attention:

"I always tell young fellows just out of medical school that I can give 'em a tip on how to build a practice *and* a reputation at the same time."

"Hey, give it to us!" said someone.

"It's simple: Always make an illness sound worse than it really is. That way, you'll collect more credit for curing your patients. And they'll pass it along."

Having given us his wisdom, Dr. Brand returned to his steak. There was an awkward silence. Then Bill Brown, a newcomer, said: "I'm not sure that's quite ethical."

The older man looked surprised. But his mouth was

full of steak, so he kept silent. The rest of us had plenty to say, though.

"Ethics aside, what if the patient goes to another doctor and is told his 'serious illness' is really minor?" asked one man. "What happens to the first doctor's reputation then?"

"Seems to me that sort of trick would give you a reputation as a pessimist," said another man. "It would alienate patients instead of pulling 'em in."

"And mightn't pessimistic talk actually slow down the patient's recovery?" observed a third doctor. "After all, his emotional state would be affected, wouldn't it?"

A highly respected internist chimed in. "Personally, I always try to play down the serious nature of an illness," he commented. "I let patients see that I'm not worried; and that means *they* needn't worry."

'You're Paid to Worry'

But still another man took up the cudgel for Dr. Brand's theory: "Don't you think your patients might appreciate your worrying over them? They're paying you to worry, aren't they?"

"Of course not," the internist replied. "They want to feel unconcerned, and I want them to feel that way, too. My pessimism might hold up their recovery."

Please Omit Varnish

"But what if you're optimistic and they don't get well quickly? Won't they lose faith in you? I wonder whether it isn't best to be neither a pessimist nor an optimist, but simply to tell your patients the unvarnished truth," said Bill Brown.

Voice of Experience

There was a brief silence while we all tackled our steaks. Then Dr. Richards—the oldest and most experienced practitioner present—spoke for the first time.

"Perhaps a little varnish is sometimes useful," he said quietly. "The way I see it, you have to modify your approach for every single patient. You can't *always* be optimistic or *always* be pessimistic. And neither can you *always* tell the unvarnished truth. I've found there are times when I feel I should avoid the direct truth. There are other times when I see it as my duty to give the patient all the facts."

"For instance?" one doctor asked, his fork in mid-air.

"Take the man with a minor illness. I want to be able to reassure him," said Dr. Richards. "I've got a hunch that worrying unduly does hold up recovery. So I try to give him the facts as I see them. I don't make light of his symptoms, of course. I never act unconcerned about any patient's symptoms, not even with a hypochondriac. When a man comes to my office, it's because he *feels* sick. It's my job to listen to him sympathetically."

"Do you put on a cheerful look with the seriously sick patient?" someone asked.

"No, I've found that the sick patient can see through anything like that. Anyway, when he's really feeling bad, he doesn't want empty optimism. He wants me to do something to help. The sicker people are, I've discovered, the more they become like children."

"I think the psychiatrists call it 'regression with symptoms of

"I was a breech, myself."

dependency,'" someone at the table put in.

"Whatever it's called, it means that forced cheerfulness or optimistic talk will do no good," said Dr. Richards. "I believe the really sick patient gets a feeling of being cared for and helped if you just hold his hand or wipe his brow—which is neither optimism nor pessimism, but *action*."

There was a murmur of assent from most of us. This was something we'd found out for ourselves.

Calmness Helps

"Some patients practically beg me to be optimistic," Dr. Richards went on. "They're the frightened ones. But they seem to feel supported and encouraged without my forcing false hope into the situation. Any doctor who's calm and authoritative and seems to know what he's doing is bound to help people emotionally."

"Well, then, what about Dr. Brand's theory?" said Bill Brown. "Do you think your patients ever want you to be *pessimistic*?"

"Certainly some do. But since I've always felt it's human nature to be hopeful, I see such persons as sick not merely in body but in mind. I encourage them to talk; and soon they expose their morbid, depressed feelings. Many of them need a psychiatrist."

Dr. Richards shook his head and continued: "No. I see no good reason for ever making an illness sound worse than it really is."

"Nor better?" asked the internist who'd been advocating optimism.

"Nor better. If a patient is dying, I may not tell him the whole truth. But neither will I tell him a lie."

There was some further discussion after that. But Dr. Richards had pretty much wrapped the topic up for most of us. He'd emphasized a basic truth: that the practice of medicine doesn't call for pseudo-feelings or attempts to play on our patients' emotions. His approach seemed ethical, rational, and the most likely to be helpful.

I can't remember what the after-dinner speaker talked about that evening. But I won't soon forget the discussion brought on by Dr. Brand's cynical tip and brought to a climax by Dr. Richards' sage advice. END

Health Insurance Through Social Security?

This medical society says a contributory plan —not a tax—may be the best way for people to pay now for health insurance benefits after 65

Most county medical societies are applauding the A.M.A.'s stand against the Forand bill.* But one such society's official publication is warning local physicians: "Organized medicine [may] do itself and the free enterprise system more harm than good" if it opposes the measure "without offering an alternative constructive program in its stead."

A strictly negative approach, say the editors of the Westchester (N.Y.) Medical Bulletin, plays into the hands of critics who charge that medicine is "more interested in the economic welfare of the doctor than in the adequate health care of the aged sick . . . We urge organized medicine to proceed at once" toward a better plan for financing the health care of the aged.

Isn't voluntary health insurance the answer? "There is little evidence thus far" that it is, says the Westchester

*H.R. 9467, sponsored by Representative Aime J. Forand (D., R.I.), would provide Federally financed hospital and surgical care for some 13,000,000 Social Security beneficiaries—most of them over 65.

Medical Bulletin. "Roughly one of fifteen . . . persons over 65 is covered with Blue Cross. Because of the actuarial experiences and health risks with the older age groups, private insurance has demonstrated no great desire to cover this segment of the population . . . We hope some combination of voluntary insurance coverage may be the answer. We fear that it will not."

What, then, *is* the answer? The editors suggest "the development of a contributory plan . . . administered through the Social Security machinery if need be." Their idea is to have people pay on an individual basis during their working years for health insurance that would cover them "on a basis other than tax derivation" after they had retired. And in support of this idea, the Westchester doctors say:

"We can think of worse threats to the sanctity of medical practice than some well-conceived plan to provide financial assistance, when needed, to the aged ill." END

Doctor's Orders

Making a night call on a new patient, I found a woman in early labor with her seventeenth child. With some difficulty, since she spoke only German and mine was weak, I told her, "You must still do a little labor." And I told her to call me when the pains increased.

I heard nothing until the next afternoon, when the woman's neighbor called to say the baby had arrived. As I hurried in the kitchen door, there, placed neatly on spread-out newspapers, were eighteen pairs of shoes, all spanking clean and shined; a dozen fresh loaves of bread were on the table.

When I entered the room whence issued the newborn's cries, the mother jubilantly told me, in German, that she'd obeyed the doctor's orders. She'd gotten up at 4 A.M., weeded the beet field, baked fresh bread, and cleaned all but one room. Then she'd had a pain and jumped into bed, and, seconds later, the baby came! —GORDON J. SCHULZ, M.D.

This Form Turns Charges Into Cash

Besides boosting collections, it can build your practice, spread your patient load, explain your fees

By Leonard Casser, M.D.

Like many of my colleagues, I've been sold on the idea of charge slips ever since I began to use them. My aide routinely gives such a slip to every incoming patient; I jot down my charges after I've taken care of him; and the patient returns the slip to the aide on his way out. As a result, on-the-spot collections have increased and our bookkeeping tasks have been eased.

In fact, the system has proved so valuable that I've devised a special kind of form for use in my practice. I call it a *multiple-purpose* charge slip. And I'd like to describe its advantages here, on the chance that other doctors might want to try something similar.

The multiple-purpose form is only a little larger than a conventional one. And it's used in much the same way. My secretary has a pad of slips on her desk. When a pa-

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THIS ARTICLE *has won one of the* 1957 MEDICAL ECONOMICS *Awards for its author, a G.P. in Cresskill, N.J.*

LEONARD CASSER, M.D., A.A.G.P.

Cresskill, N. J.

Patient's Name Edward Jones Date 3/1/58

PLEASE GIVE THIS SLIP TO THE RECEPTIONIST

Next Appointment 3 mos.

For BMR. in Lab.

RECEPTIONIST TO MAIL APPOINTMENT REMINDER: ✓

RECEPTIONIST TO GIVE PATIENT TODAY:

Tablets ( ) Diet (17-A)

Instructions (✓) Informational Forms ( )

Services and Charges

1st Office Visit	$5
Office Visit (Weekdays 8 A.M.-5 P. M.)	4
Office Visit (Evenings or Saturdays) ✓	5
Emergency	10
House Call (Weekdays 8 A.M.-5 P. M.)	6

MULTIPLE-PURPOSE CHARGE SLIP designed by Dr. Casser is shown here larger than life-size. On such a slip the doctor indicates services rendered and fees charged (plus follow-up instructions) at the end of each office visit. Then he asks the patient to

House Call (Weekdays 5 P. M.-11 P. M.)	7
House Call (Weekdays 11 P. M.-8 A.M.)	10
House Call (Sundays and Holidays A.M.)	7
House Call (Sundays and Holidays P. M.)	10
Injection (Intravenous or Intramuscular)	1
X-ray	10
Drugs and Supplies	$1
Diagnostic Test	
Surgery	
1st Insurance Form	0
2nd or Additional Insurance Form	5
Letter to Lawyer	5
Complete Case Summary	5
TOTAL CHARGES	$6

RECEIPT FOR CASH

Date 3/1/58

Received $6.00 From Edward Jones

Thank You!! Per J. B.

take the slip back to the aide's desk. There she arranges the next appointment. And if the patient wants to pay cash, she fills out the bottom of the slip and gives it to him as a receipt. For further details about Dr. Casser's system, see the accompanying text.

tient comes in she writes his name and the date on a slip, then clips it to his case history.

Before the patient leaves my office, I indicate the appropriate charges on the form. If he needs another appointment, I put down an approximate time, along with any other information my receptionist should have. And I also indicate whatever literature, medication, or instructions I want the patient to get before he leaves. All this takes me about thirty seconds. I then ask the patient to give the slip to the aide.

A Collection Aid

If you examine the sample form on pages 94-95, you'll see why I call it a multiple-purpose slip. For one thing, like any charge slip, it tells both patient and aide what the fee is; thus it encourages cash payments. In addition, it protects me from my own possible forgetfulness by itemizing *all* charges.

In the example shown, note the $1 charged under "Drugs and Supplies." Let's say I gave the patient a chest bandage or some other small item not connected with his main reason for coming in. That extra service could easily have escaped my memory if I hadn't jotted it down on the spot.

Then, too, the slip tells my secretary all she needs to know about the patient's next appointment. So she can prepare the patient for the appointment without asking me for further instructions.

For instance, the sample form makes it clear that a basal metabolism test is to be done in the lab in about three months. It also tells my aide to give the patient a special diet plus instructions for preparing for the BMR. And it indicates that I want the patient reminded of his appointment in advance.

Even more important is the very explicit schedule of fees. I've found that most patients study the list with great interest. Many of them have told me it has made them strikingly aware of all the services I offer. So in that respect the slip is something of a practice-builder.

It Explains Fees

What's more, the fee schedule prevents misunderstandings. The patient who pays $5 for an office visit instead of $4—or $10 instead of $6 for a house call—knows exactly why. MORE▶

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Available on prescription only.

TABLETS *(sugar coated) Each Tablet contains:*

ACHROMYCIN® Tetracycline	125 mg.
Phenacetin	120 mg.
Caffeine	30 mg.
Salicylamide	150 mg.
Chlorothen Citrate	25 mg.

Bottles of 24 and 100.

SYRUP *(lemon-lime flavored) Each teaspoonful (5 cc.) contains:*

ACHROMYCIN® Tetracycline equivalent to tetracycline HCl	125 mg.
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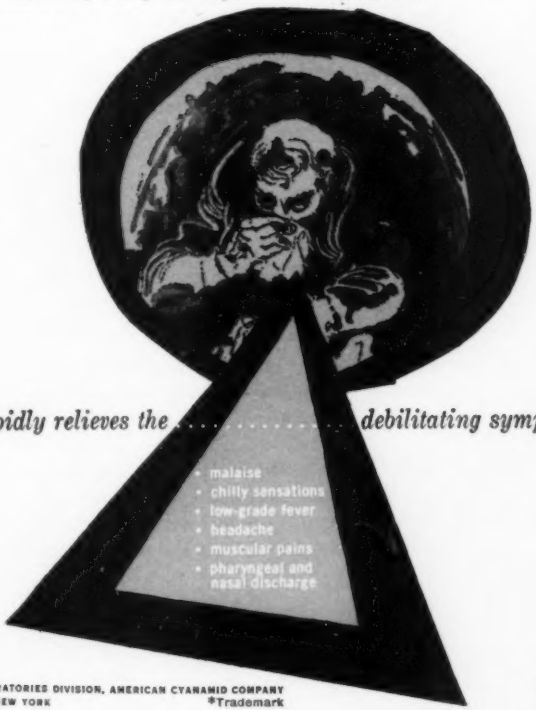
Salicylamide	150 mg.
Ascorbic Acid (C)	25 mg.
Pyrilamine Maleate	15 mg.
Methylparaben	4 mg.
Propylparaben	1 mg.

Bottle of 4 oz.



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The slip has actually educated some patients into taking advantage of the lower rates for certain days and hours. Every doctor knows it's harder to fill weekday afternoons than evenings or Saturdays. But by this constant reminder of the difference in fees, I've successfully managed to equalize my patient-load. And I'm routed out of bed much less often than I used to be.

Finally, note that the fee schedule includes a number of nonmedical items. It lets the patient know, for instance, that I don't charge for filling out a single health insurance form, but that I ask a fee for doing more than one. I also charge for writing letters to lawyers and for preparing detailed case summaries for the use of other doctors.

I think it only fair that I should be paid for such time-consuming services. I think it equally fair that my policy should be made known to all patients—as it is on the multiple-purpose charge slip.

Might some patients consider such slips too businesslike? Not judging from my experience. I've heard no complaints about them. To the contrary, a number of new patients have said they're delighted that there are no surprise charges or hidden fees in my office. · END

Snap Diagnosis

I'm an obstetrical resident, and a bit on the plump side. One day in the prenatal clinic I had to give a patient a stern talking-to for having gained too much weight during her pregnancy.

When I'd finished, she smiled. "You don't seem worried about *your* excess weight," she said.

"But *I'm* not pregnant," I pointed out.

"Oh, I'm sorry," she snapped. "Your appearance deceived me."

—R. F. BORRELLI JR., M.D.

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further intensifies analgesic effectiveness by combining the analgesic action of 'Darvon' with the antipyretic and anti-inflammatory benefits of 'A.S.A. Compound.'* It is particularly useful in relieving pain associated with recurrent or chronic disease, such as neuralgia, neuritis, or arthritis, as well as acute pain of traumatic origin. In a study of 101 patients, Gruber[1] has shown that, even after prolonged administration, no loss of analgesic potency occurs with 'Darvon.' No contraindications have been reported.

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Dosage: *'Darvon Compound'—1 or 2 pulvules every six hours as needed for pain.*
'Darvon'—32 mg. every four hours or 65 mg. every six hours as needed for pain.

*'A.S.A. Compound' (Acetylsalicylic Acid and Acetophenetidin Compound, Lilly)

1. Gruber, C. M., Jr.: J. A. M. A., *164*:966 (June 29), 1957.

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12 Tax Problems You May Face

By Joseph F. McElligott

In the Federal income tax field, as in medicine, the general theory is often crystal clear. It's the concrete case, with its attending complications, that may confuse you.

Any of the following tax problems might well resemble one of your own. See how your answer compares with what I told the doctor who originally posed the problem:

Problem #1: When a long-time patient died last May, he willed me an amount equal to the total he'd paid me in doctor bills over the past ten years. He'd said he'd always felt my services were worth twice what I'd charged him (though I'd always billed him at my regular rates). Should I treat this $3,500 legacy as compensation for services—and thus as taxable income?

Solution: No. You were paid for your services as you performed them. The bequest was intended simply as an expression of gratitude and is not taxable income.

Tax-Saving Sale

Problem #2: Now that our children are grown up, my wife and I would like to sell our home and move into an

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THE AUTHOR *is a New York City tax and medical management consultant who formerly worked for the Government as an Internal Revenue agent.*

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'V-Cillin-Sulfa' combines the superior oral penicillin and three sulfonamides. Used concurrently, they produce faster and more effective antibacterial action in certain infections. In general, the combination is most beneficial in mixed infections, infections due to bacteria only moderately susceptible to either agent, and conditions in which bacterial resistance might develop. The much higher penicillin blood levels produced by 'V-Cillin' (Penicillin V, Lilly) and the effectiveness and safety of the triple sulfas make 'V-Cillin-Sulfa' your most valuable preparation of its type.

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Each tablet or 5-cc. teaspoonful provides 125 mg. (200,000 units) 'V-Cillin' plus 0.5 Gm. triple sulfas.

*'V-Cillin-Sulfa' (Penicillin V with Triple Sulfas, Lilly)

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apartment. I'd make about a $20,000 profit on the sale. And at my present income level, I'd pay a capital gains tax at the full 25 per cent rate. Is there any way I can sell the house now, while prices are high, but hold off on receiving the money for a while? Since I'll be retiring in a few years, my capital gain at that time would be taxed at a lower rate.

Solution: You can't postpone the whole amount. But I suggest you look into the possibility of an installment sale. This would give you only a part of the sale price each year for a fixed number of years. Before making such an income-spreading arrangement, be sure the sale conforms to all the special requirements of the tax law governing installment sales. You'll need the help of a competent lawyer.

Sick-Pay Benefits

Problem #3: I know that if an employe continues to get his salary while sick, he can consider up to $100 a week as tax-free sick pay rather than as taxable income. But what about a man who's not an employe? In 1957, one doctor in our three-man partnership got his regular share of partnership income while he was out sick for four weeks. May he exclude $400 ($100 a week) from his taxable income?

Solution: No. The law allows such sick-pay exclusions only to bona fide employes.

Dependent Child

Problem #4: My son drives to college in a near-by city every day and takes along four classmates as paying customers. The amount he collects runs over $600 a year. Do I lose him as an exemption on my tax return?

Solution: No, for two reasons. First, the Treasury regards such car-pool money not as income but merely as reimbursement for operating expenses. Secondly, even if any of your children

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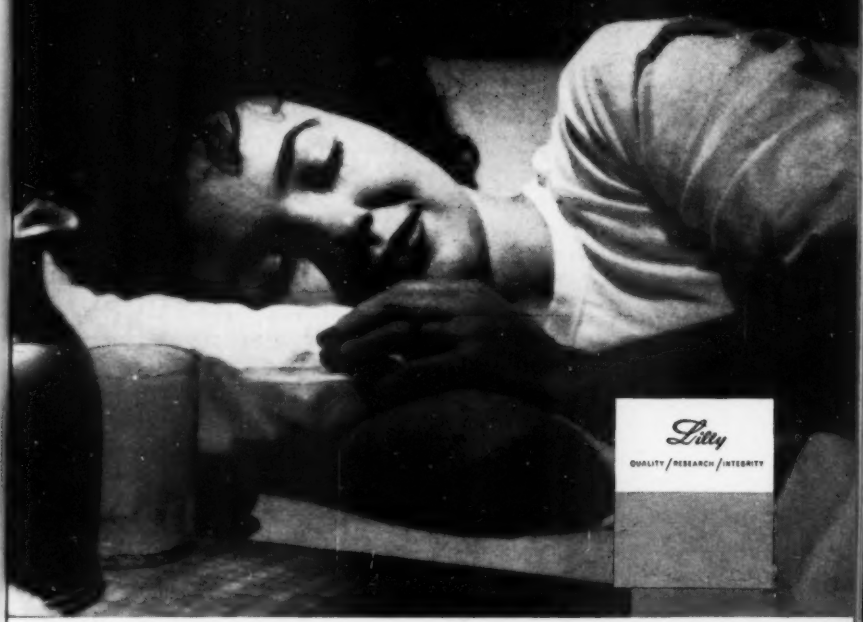

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has a taxable income of over $600, the law allows you to claim him as an exemption if he's either under 19 or a full-time student. (In all cases, of course, you must furnish more than half his support.)

Moving Expenses

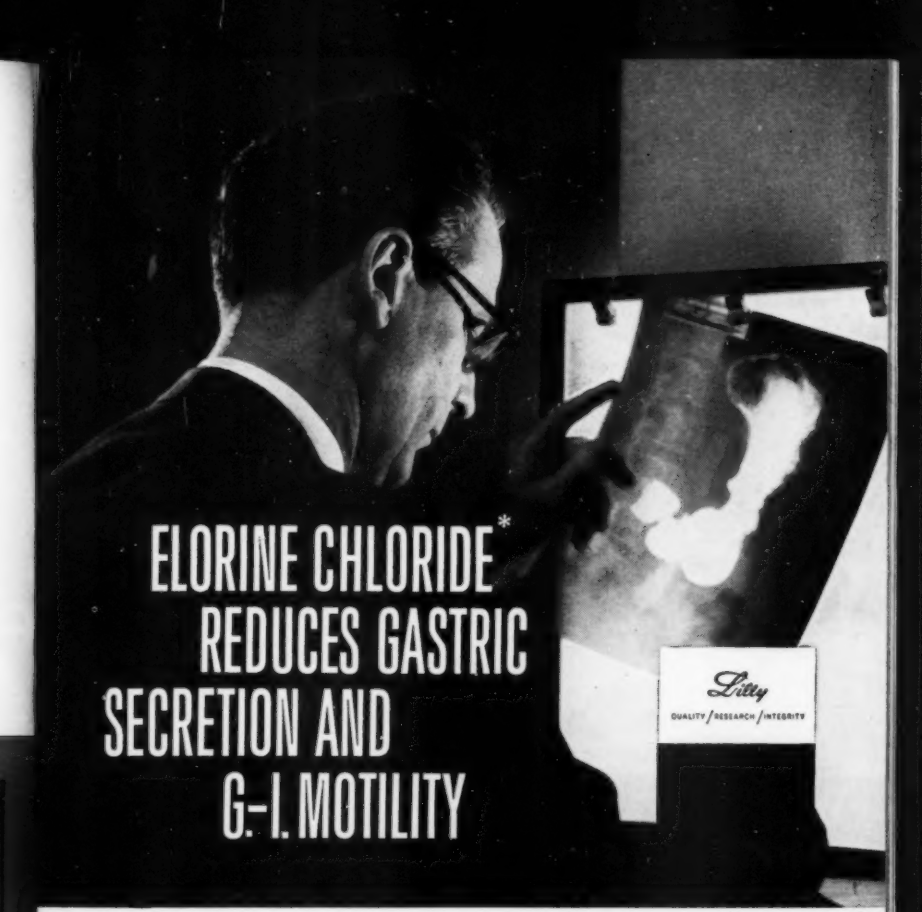
Problem #5: Last year, I hired a salaried assistant and paid the cost (about $500) of moving his family here from another part of the country. Can I deduct this amount as a business expense? And if I can, should he report it as income?

Solution: Yes, you may deduct this as a business expense. And your employe doesn't have to report it as income. Payment of moving expenses is standard procedure with many firms.

Income Limits

Problem #6: My father lives on $3,000 a year. I supply about $2,500 of it. The rest comes from his own rental income of $800 (which nets him about $500 after expenses and real estate taxes). Can I claim him as an exemption?

Solution: No. Though you do



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*'Elorine Chloride' (Tricyclamol Chloride, Lilly)

1. Sun, D. C. H., and Shay, H.: A.M.A. Arch. Int. Med., *97*:442, 1956.

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furnish more than half his support, he has a gross income of more than $600. And it's a dependent's *gross* income—not his net—that must be under $600.

House-Swapping

Problem #7: My family has outgrown the $20,000 home we own. My wife's parents have suggested we simply swap our small house for their bigger one, which is worth at least $30,000. If we accepted their offer, would I have to pay taxes on a $10,000 gain?

Solution: No. But if you later sold the second house for $30,000, you'd then have to report the $10,000 taxable gain.

Small Home-Office

Problem #8: May I deduct an allocated share of house expenses to cover the cost of running an office in my home that I use only about an hour a night for evening office calls?

Solution: Yes, provided the room is equipped as an office and isn't used during the day as part of your home.

Legal Costs

Problem #9: Last year, I paid $500 for the legal costs of acquiring a small office building. May I deduct the expense on my 1957 return?

Solution: No. Legal costs incurred in buying or leasing professional property are regarded as a capital expense and aren't immediately deductible. You can recover the money by amortization in the same way that you recover the cost of the building itself.

Error on Return

Problem #10: If my tax accountant makes an error on my return, am I responsible for it?

Solution: Yes. In fact, even if a man from the Internal Revenue office helps you prepare the return, you're still held responsible for any mistakes he might make.

How Many Meetings?

Problem #11: I attended four medical meetings last year. May I deduct the costs of all of them on my tax return? Or does the Treasury set some limit on such deductions?

Solution: You can deduct all legitimate costs of all the meetings you attend. But make sure you can prove you haven't in-

cluded any purely social expenditures in the total amount claimed.

Non-Deductible Trips

Problem #12: I've made some rather costly trips in order to study the possibilities of practice in another part of the country. Can I deduct such expenses?

Solution: No. These expenditures weren't necessary for the practice that furnished your income in 1957. So the Treasury wouldn't regard them as practice-connected expenses. END

first thought for high b.p.*

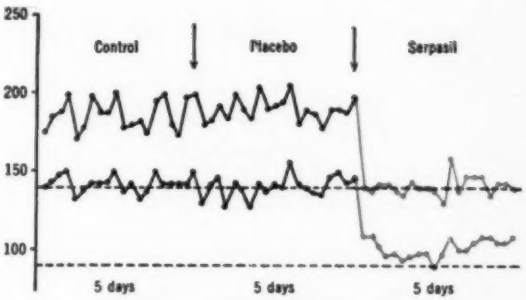

*Chart shows actual response to Serpasil in a patient with benign essential hypertension (data on request). Consider Serpasil® (reserpine CIBA) (1) alone to lower blood pressure gradually and safely in most cases of mild to moderate hypertension; (2) as a primer in severe hypertension before more potent drugs are introduced; (3) as a background agent in all grades of hypertension to permit lower dosage and thus minimize side effects of other antihypertensives. **C I B A**

How to Improve Your

Here are some tips for the doctor who wants to train his patients, as well as himself and his aide, to keep the office schedule on time

By John E. Eichenlaub, M.D.

Suppose you've trained your aide—and disciplined yourself—to keep office routine rolling on schedule. You still may not have a smooth-running appointment system. It takes three for that.

How can you win the cooperation of that crucial third member of the team, the patient? Here are some ways in which physicians of my acquaintance do it:

1. *They keep pointing out the advantages the patient gets if he's prompt.* A number of my colleagues have trained their aides to talk about future appointments in terms that emphasize the advantage *to the patient*—in-

Appointment System

stead of to the office—of keeping on schedule. The following paired statements show how this shift in emphasis can be carried off:

Weak: "Dr. Hansford has one opening Tuesday, at 10:30."

Strong: "Dr. Hansford can give you a full half-hour if you're here on the dot of 10:30 Tuesday."

Weak: "Dr. Hansford likes his new patients started before 11, so they won't run into the lunch hour if they need lab work."

Strong: "Since you're a new patient, Dr. Hansford will want to see you early in the morning. Then he'll probably be able to finish all the studies you need in one visit."

Weak: "Please be on time Tuesday, because you'll be the doctor's first patient and he likes to get started right away."

Strong: "Dr. Hansford will see you right away if you're

here on time. He always gets to the office promptly at 9, and you'll be his very first patient on Tuesday."

2. *They train patients not to come to the office without phoning for an appointment.* A check of your records will probably show you that the bulk of schedule interruptions come from old patients, not new ones. Most of the time, the patient who barges in feels that his problem is urgent and that he knows you well enough not to stand on ceremony.

There are several ways of educating such persons up to the need for making preliminary phone calls. Some doctors simply charge an extra fee for seeing a patient without an appointment —except, of course, in a real emergency.

But there are gentler ways to make your point. Listen in, for example, on a certain pediatrician as he instructs a mother regarding acute illnesses:

"Don't let your thermometer settle the issue whenever Susie gets sick. Most youngsters get high fever in the evening. If you wait for that, you may be in for

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extra delays and expense. Instead, the minute you suspect she's ill, give me a call. I'll decide whether I need to see her. And we'll be able to arrange an appointment for you, even if it has to be outside regular office hours."

Another sound approach is to warn your patients of the kind of trouble their particular ailments might give them. Then you can tell them what to do about it if the trouble comes. A near-by cardiologist tells me his schedule runs like clockwork because he does just that.

"I tell my patients exactly what should make them call me," he says. "The minute they get extra swelling, dyspnea, or pain, they phone for an appointment. So they practically never get to the point of needing urgent care before I've seen them during routine hours."

Write It Down

3. *They use cards or other reminders to keep the patient from forgetting his appointment.* I know one doctor who gives out miniature calendar cards with the crucial date circled in red and

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the time noted below. Another fills out appointment cards himself. Then he completes and files a stub right before his patient's eyes.

This last method takes little more time than instructing the patient to get an appointment at the front desk. And it seems especially good to me because it gives the patient a sense of personal obligation. As a result, he's likely either to show up on time for the appointment or to cancel it well in advance.

Another approach is through the educational emphasis of repetition. An internist friend of mine uses repetition in what at first glance seems a clumsy office routine. He fills out a routing slip in his consulting room and hands it to the patient. "Take this to Miss Jones," he says. "She'll give you an appointment for next Tuesday."

The patient inevitably reads the slip, which specifies the date. Miss Jones carries on from there. "The doctor wants to see you next Tuesday, Mr. Bullitt," she says. "Will 10 o'clock on Tuesday the 25th be all right?" She turns the desk calendar so he can


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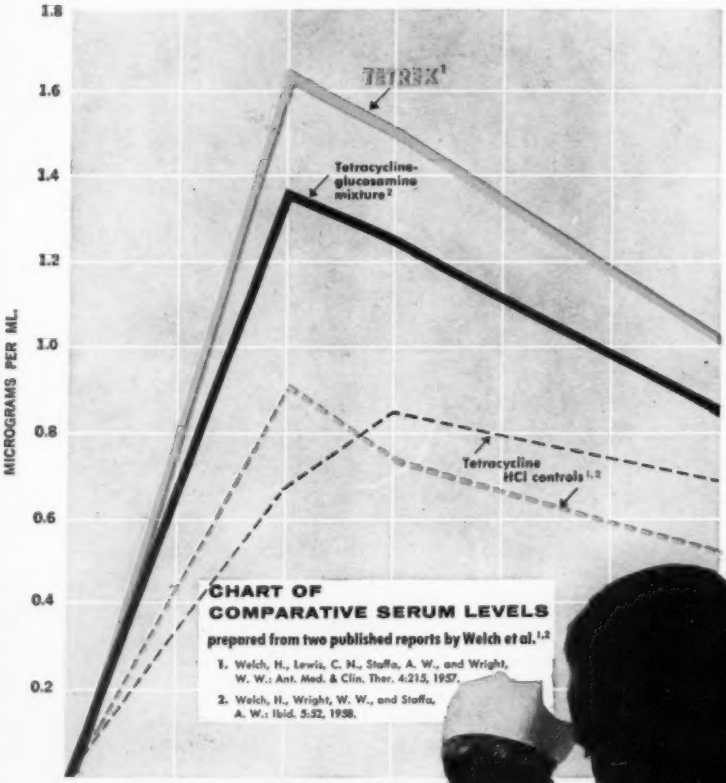

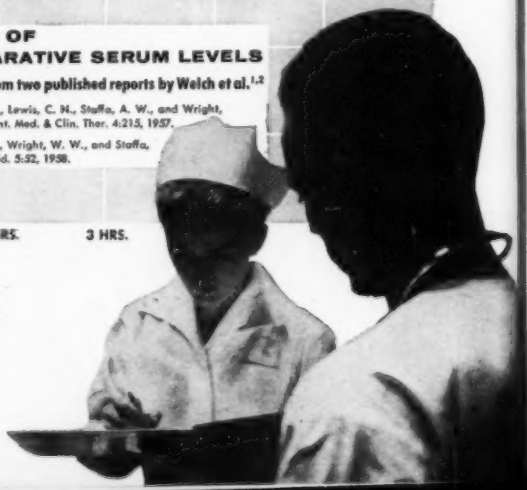

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- **More than 170 million doses of tetracycline phosphate complex during 1957.**
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- **"All patients infected with tetracycline-sensitive organisms responded satisfactorily to [Tetrex] therapy."[3]**

REFERENCES: 3. Cronk, G. A., Naumann, D. E., and Casson, K.: Fifth Annual Symposium on Antibiotics, Washington, D. C., Oct. 2-4, 1957. 4. Cronk, G. A., and Naumann, D. E.: Ant. Med. & Clin. Ther. 4:166, 1957. 5. Prigot, A., Shidlovsky, B. A., and Felix, A. J.: Ibid. 4:287, 1957. 6. Putnam, L. E.: Ibid. 4:470, 1957. 7. Rein, C. R., and Fleischmajer, R.: Ibid. 4:422, 1957. See also Report by A.M.A. Council on Drugs, J.A.M.A. 166:52, 1958—to be published in New and Nonofficial Remedies.

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see it, and points to the date with her pencil.

"Fine," the patient says.

"Then that's 10 o'clock," Miss Jones repeats, writing on an appointment card. "Tuesday, February the 25th. There." She hands him the card. "Read it over and be sure it's right. Ten o'clock on the 25th."

He Won't Forget

The patient has had his attention directed to the date verbally or visually at least eight times in a few minutes. As he walks out the door, Miss Jones may add once again: "See you next Tuesday!"

A clumsy routine? Not at all. Repetition of this sort isn't particularly noticeable. Yet it provides a splendid jog to the memory.

If you want a forgetful patient to remember his appointment, there's another simple approach: Remind him of it when it's almost due. Some doctors have their aides phone every patient a day in advance. Others notify only those who've shown they're forgetful by failing previous appointments.

If you see many people who are hard to reach by phone, postcard reminders may be more practical. One gynecologist's aide makes a carbon of the cards she gives or mails to the patient at the time the appointment is made. She sends the carbon two days before the crucial date.

A friendly G.P. uses postcards printed "We'll be seeing you (*day of week*) at (*time*)."

An internist near-by uses more formally worded cards with his secretary's signature rather than his own.

These doctors' aides agree that the simplest method is to complete the cards when the appointment is made. Then they're filed by date for routine mailing.

See Them Promptly

4. *They make the patient feel that the appointment system works more smoothly than open office hours would.* Patients naturally resent the double standard some physicians impose on them: "Be on time, so I can take you whenever I get around to it," one nurse-turned-patient has called it. Such resentment often leads to future slow-show visits. To put it more positively, promptness begets promptness.

My partner points out that the promptness that counts is prompt

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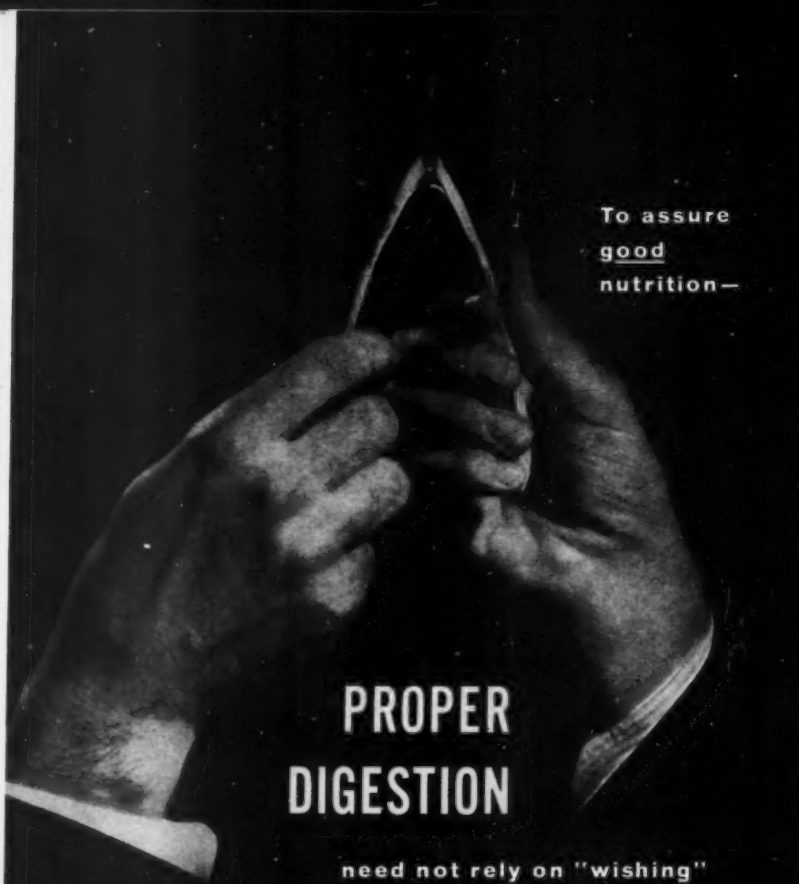

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beginning, not prompt ending. If you see a patient at 10:30 as planned, he won't mind so much if he's still around at noon. When my partner gets behind, he sends one man to the lab. He'll finish the next man's history and start him undressing in an examining room while he calls in the next. Sometimes he winds up with patients spread all over the office. But he stays on schedule; and his patients are punctual too.

What if you can't see a punctual patient right away? Well, Dr. Carter has a big surgical practice that involves many unscheduled procedures. He keeps his patients coming on time by seeing that they get plenty of notice and approval whenever they can't have prompt care. His secretary dates each record when the patient comes in; she makes a check if he's on time. Then if Dr. Carter's behind schedule, he greets the patient like this:

"Sorry I was late, Mr. Edwards. Miss Brewster tells me you were right on time."

Miss Brewster also does her bit. She always remarks on today's punctuality when she makes next week's appoint-

ment. And she does everything in her power to make sure the man who's kept waiting today won't have to wait next week.

What about the fellow who shows up late? An obstetrician's aide rebukes such persons mildly by saying something like: "Dr. Peterson's next patient was a little early, so he took her in your place. He should be able to work you in soon, though."

Finally, it's not difficult to train patients who can't honor appointments to cancel in advance. Says one physician who stresses the importance of cancellations: "My secretary always

Clinico-Pathological

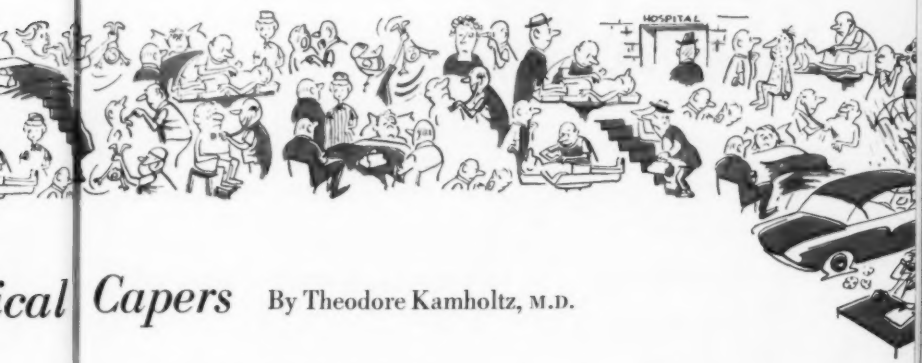
The clinico-pathological conference is a fine and instructive institution. It sheds new light on medical science—and even more on medical men.

It starts with a melancholy recital: "The patient, age this, race that, gender the other, was admitted to the hospital on such and such a date complaining of —" It ends: "Despite heroic measures, he expired on his nth hospital day." Discussion follows, with the pathologist finally giving the findings and his interpretation of the case.

It's in the discussion that doctors reveal more of themselves

tells patients to feel free to cancel. Our appointment cards give the telephone number and request cancellation. And anyone who cancels gets our thanks and a new appointment, not grudging consent."

When the patient gets used to making appointments and keeping them, he soon learns the value of the system. Once he does, he has acquired a habit he won't break lightly. And *you've* acquired an asset that's well worth the trouble: a patient who'll help you serve all your patients better by arriving when you expect him. END



Capers By Theodore Kamholtz, M.D.

than the minutes ever show. There is always one physician who, no matter what the clinical history, will always make his favorite diagnosis. He rides his enthusiasm to the detriment of his judgment. Usually he chooses something like periarteritis nodosa—and explains how it will mimic every other disease. (After the pathologist has explained his findings—*not* periarteritis nodosa—this man will rise to say rather belligerently that his favorite has not been entirely ruled out.)

Then there is the statistical-minded doctor. The patient died

at age 59? He has a list of the principal causes of death at 59. He runs through it until he comes to one that is not too incompatible with the patient's story. All this is fair enough, except that it would work just as well if the doctor who suggests it hadn't seen the protocol and had simply diagnosed an unknown corpse.

The Main Speaker

The eminent guest who delivers the main discussion of the differential diagnosis usually states in his first sentence what his conclusion will be. Then, to take up the slack of the fifteen minutes allotted him, he gives the cause of hemoptysis, pain in the abdomen, headache, and anemia, explaining carefully his reasons for thinking that this particular cause doesn't jibe with his list. The textbooks exhausted, the professorial gesture completed, he sits back to await the pathologist's confirmation with impatience.

A Different Idea

Another doctor states his concern over a finding that everyone else has ignored. This finding has caused him to abandon the line of thinking the others have followed (and also,

MY DAD— HE HURT HIS BACK REAL BAD

"It happened at work while he was putting oil in something"

"He told Mom his shoulder felt like it was on fire"

"He couldn't swing a bat without hurting"

"But Doctor gave him some nice pills -- and the pain went away fast"

"Dad said we'd play ball again tomorrow when he comes home"

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in the process, to slight almost every other symptom and sign). Such a man is always getting trapped by contaminated cultures, a new interne's enthusiasm, and the like.

The Attending M.D.

The doctor whose patient is being discussed then identifies himself—either timidly or belligerently, depending on the circumstances. He points out that this was a difficult and confusing case. He delivers many observations not included in the protocol: how he happened to get

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stuck with this patient, why it took two weeks to get surgical (or medical) consultation, and so on. He is diligently preparing the loophole through which he can duck.

Since everyone wants at least one sentence of his golden wisdom recorded in the minutes, there follows a group of quick questions, quibbles, and protests. Finally, and with a fairly audible sigh of relief, the chairman raps for attention and says: "Gentlemen, the time is growing short. I think we should hear from the pathologist."

Pathologist Triumphs

For the pathologist, this is the Great Moment. He can never be a hero to a patient. He must abide the continual intimation that the data arrived at in his laboratory should be taken with a grain of salt. This conference is his operating room, and his scalpels are not reserved for the deceased alone.

"Gentlemen, this is an interesting case . . . The lungs showed focal areas of bronchopneumonia (the radiologist had reported the chest as clear); the spleen was 60 grams and small for a patient this size (a reportedly enlarged spleen had been palpated); a tight mitral stenosis was observed (the cardiologist heard nothing). And there was marked pulmonary edema (the patient received x liters of physiologic saline by infusion)."

Therapy 'Mishandled'

He flashes the histological slides on the screen, pointing out pathologic cells with broad gestures that leave all but the most acute fellow pathologist in the dark. On he goes to his conclusion, stating the diagnosis and the various turns at which it was missed (and could so easily have been discovered), how the therapy was mishandled, and so on and on.

A truculent doctor asks how it happened that a faulty report of a positive blood culture for typhoid was placed on the chart. Before the pathologist has a chance to explain that he is understaffed and that the technicians he does have are not so reliable as he would wish, the auditorium is empty.

Only the doctor of the patient, who needs a few words of comfort, remains behind to venture, "It was an unusual case, wasn't it?" END

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Too Much Professional Courtesy?

By Saul Rosenberg, M.D.

Tell me, Doctor, how much professional courtesy is too much? And if you can answer that one, can you also tell me how to deal with the problem of drawing the line? As for me, I'm baffled.

The Hippocratic oath enjoins us to treat without charge our teachers, our colleagues, and their immediate families. So Dr. X, Mrs. X, and the X offspring are as my own when it comes to medical care. But what about all the other claimants to free treatment who turn up in our complex society?

To begin with, there are the many members of my own tribe and my wife's tribe. I have aunts, uncles, cousins, in-laws—in short, dozens of relatives who call me by my first name.

When the families assemble, I'm not regarded as a host or guest. No, I'm the member of the crowd whose particular offering is going to be medical advice. Like a visiting opera singer, I'm suppose to be flattered when

---

THIS ARTICLE *has won one of the* 1957 MEDICAL ECONOMICS *Awards for its author, a Bridgeport (Conn.) dermatologist. Questions like those posed by Dr. Rosenberg have led this magazine to make a new study of the ways in which U.S. doctors handle the problem of professional courtesy to non-M.D.s. First findings will be reported in the next issue.*

I'm asked to give a performance.

Occasionally, to be sure, a relative is conscience-stricken by his presumption and feels impelled to make a gesture. Take the cousin who led me away from the dinner table into my consulting room for a look at his rash. This done, he extracted $2 from his wallet and handed it to me. "Now, I know you don't want to charge me, but I'm not the kind that takes something for nothing," he said.

In other words, a tip. That gratuity covered ten or fifteen later consultations plus Rx renewals.

He Paid—Once

Then there was my uncle-by-marriage who announced with great ceremony he was going to pay me for the first visit. Once he'd made this token recognition of my status, he claimed his rights as a member of the family. Nor was there any reciprocation. When his firm repaired my roof the next season, a bill arrived in due time with no deduction for the first day's work.

Call me a coward, but I've fallen back on a spineless criterion for charging relatives: If they don't offer to pay me—nay, insist—I don't ask.

I'm also stumped by my obli-

gation to practitioners in allied fields of health. The six members of my family attend three different dentists. My own dentist takes off 25 per cent of the bill; my wife's dentist takes off nothing; my children's dentist grants a 10 per cent reduction. So when it comes to dentists, I have to begin by figuring out which member of my family is the contact.

Why Not Animals Too?

On the other hand, the veterinarian who delivered my cat of six kittens and subsequently neutered her (a bona fide hysterectomy) refused to charge even when I protested. Now, do I treat his animals free? Or him, or his human family? Or the whole crew?

Sisters in Medicine

What about nurses? I actually hate to take their hard-earned money. Are they not the handmaidens of medicine? And did they not help teach me how to make a bed, process a bedpan, give a bed-bath? So I don't bill them as a matter of course. Yet, once the bar is down, all the nurses may enter—including the one from Milwaukee who's taken ill while visiting her friend in my town.

Finally, there are the special

cases of other doctors' relatives. Should I go on giving professional courtesy to the doctor's widow who's now married to a banker? Or to her children by the second marriage as well as by the first? And how about doctors' parents? I won't soon forget the elderly cardiac I treated free for a year because her son was a doctor in Florida. I eventually learned he was a naturopath.

Embarrassing Question

I have heard that some of my colleagues will ask, in the case of doctors' parents, whether the pa-

tient is financially dependent upon his or her son. If the answer is no, a bill is sent. But such questions don't trip easily off my tongue. When somebody tells me her son's a doctor and I catch that so-I-get-professional-courtesy look in her eye, I'm stymied.

Ministers' Attitudes

Nor am I any more courageous with the clergy: Ministers of every faith have come to my office. I try to do what they apparently want me to do. One noble preacher argued that he had a *right* to pay the full amount. Another graciously accepted a 50 per cent discount. A third was open-mouthed with surprise when I merely mentioned payment. I cringed and changed the subject.

Druggists, by All Means

Consider, too, the druggists. Think of the Christmas presents, the discounts on supplies, the cheerful service, the referrals they can steer my way. What is to be their reward? Professional courtesy, obviously.

Last, but by no means the least puzzling, comes the never-never-land of neighbors. When a neighbor walks into my home-office, I assume that the usual procedure is to be followed: examina-

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tion, treatment, and fee. I make that assumption even when she begins by saying: "I can't reach my own doctor. So I thought that since you're right around the corner . . ."

What's Neighborliness?

But what about the neighbor who knocks on the back door and leads her frightened, bleeding child into the kitchen? When my wife herds them into my office and I drop everything else in order to help the child, do I deem it medicine, first aid, or neighborliness?

And what about my daughter's friend who fell from the swing in our yard and skinned her knee? Under what category did the swabbing and bandaging fall? Or the case of our little overnight guest who was once stricken with an asthmatic attack at 2 A.M.? Or the baby-sitter who wanted

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something for her cold? Or the casual cleaning woman who confessed that she had a serious infection requiring immediate attention?

'Psychological Impetus'

Are the above questions out of order? I think not. Medicine is medicine, and responsibility and payment go together. You don't have to be greedy to believe that the man who pays for his treatment brings a certain psychological impetus to his recovery. What's more, the paying patient retains the right to ask questions, to seek the time for reassurance, and to dismiss the doctor altogether if he chooses to do so.

It's my privilege to give Dr. X, Mrs. X, and the X offspring the fullest measure of my professional skill. But the fact is, they comprise only a small percentage of the total who expect not to pay.

A Plea for Help

Tell me, Doctor, what *should* I do about all those other people? I'd accept your help as a really valuable professional courtesy. I know others would too. END

Let Residents Run Private Pay Clinics?

Sure, it's competition for private physicians. But it's one way to give surgical residents all the training they need, this doctor says

You've heard talk about using private patients for teaching purposes. Usually it's just "one of those pat solutions which are often so glibly offered but are almost always so completely meaningless," says Dr. Allan C. Barnes, chairman of the Department of Obstetrics and Gynecology at Western Reserve. But when Dr. Barnes talks about using private patients, he doesn't pull his punches. Here's his analysis of one possible solution:

If everybody had health insurance, he says, surgical residents could become "the responsible partners in a private-type clinic, with the visitants serving only as shadowy consultants."

Such clinics could collect usual fees in behalf of the residents, he adds.

Good surgical training requires "the transfer of responsibility to the resident," Dr. Barnes explains: "Unless the selection of the patient who is to be committed to surgery is originally his; unless the postoperative management rests on him, and . . . the responsibility of talking with the friends and family in the event of complications; unless in short she is *his* patient in the best sense of the

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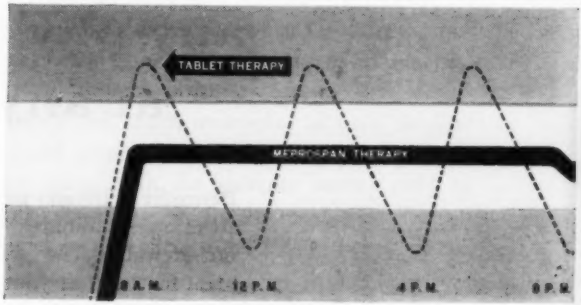

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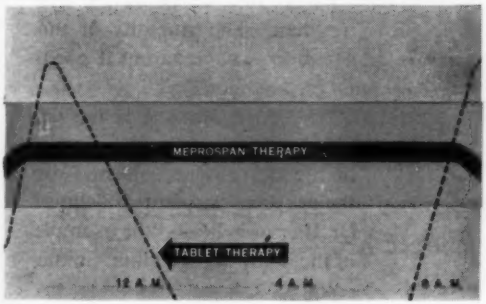

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word, then we will train [merely] a group of accomplished technicians."

There are three obstacles to the plan, Dr. Barnes notes, all of them surmountable:

A.M.A. Objects

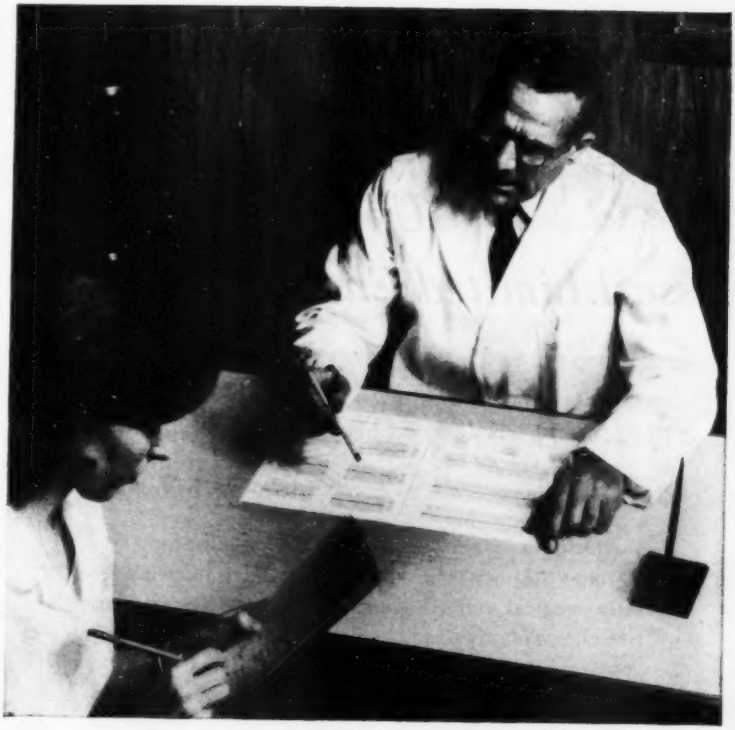
"First, the A.M.A., acting through . . . the local county medical societies, screams 'unfair competition' . . .

"That it *is* competition [to private practitioners] is inherent in the very nature of the proposal. That an established practitioner should feel resident competition 'unfair' speaks poorly for the quality of his own medical service . . ."

The second obstacle is the attitude of the insurance companies. Dr. Barnes points out that his state "does not require an interneship prior to practice. Therefore a man who graduated from medical school last year and is in private practice this year may collect from Blue Shield . . .

"[But] a man with an interneship, a year of training in general surgery, and three and a half years of thorough specialized training in obstetrics and gynecology cannot collect insurance . . . because he bears the title 'resident.' The stupidity of this situation is so apparent it needs no further comment."

The third obstacle is the tax law: "Who pays the income tax on the total monies collected" by the proposed resident-run clinic? Dr. Barnes believes "the example of the many private clinics in this country" shows that this tax problem is "susceptible to ready solution. Unfortunately, the reaction of the average physician to the tax [problem] includes so much palmar perspiration that it often makes him oversensitive on this topic." END



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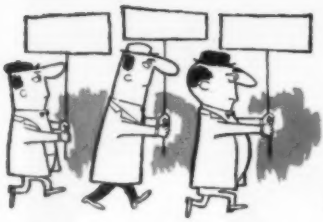

Union Members Assail Limited Choice of M.D.

'Free choice has failed,' top U.M.W. officials decided. But when they cut down their lists of approved physicians, 9,000 miners protested

By John R. Lindsey

Doctors from Pennsylvania to Colorado have long been warning the men who administer John L. Lewis's 26-state medical empire against denying union members free choice of physician. Now they're getting some strong support from an unexpected source: rank-and-file members of Lewis's United Mine Workers of America.

If Lewis has been able to ignore doctors' complaints up to now, he may not be able to much longer. To date he's had letters from eleven U.M.W. locals representing 9,000 miners in four Ohio counties. All complain that union policies deprive miners of adequate care.

For example, says Lester Zimmerman, president of U.M.W. Local 283 in Cadiz, Ohio, "the list of participating physicians in our county has been cut to four. Since then one of the four has resigned . . .Another on the list has been hospitalized by a heart attack.

"That," says Zimmerman, "leaves us with only two

doctors in the whole county for 2,081 miners and probably 3,000 more of their dependents."

Zimmerman is the man who headed a miners' delegation that went to Washington early in the year to present their complaints to John L. Lewis in person. Here's how Zimmerman has summed up his complaints since then:

"When the doctors were deleted from the U.M.W. list, it left whole communities and many miles of territory without medical services." Seven of the eleven hospitals to which Cadiz miners would find it convenient to go have also been cut off the list. And since the four remaining hospitals were overcrowded, "it left our membership without bed space in any hospital whatsoever."

Zimmerman's complaint (and others like it) backs up what the doctors have been saying all along. He doesn't yet know what effect it will have on Lewis or the Fund's executive medical officer, Dr. Warren F. Draper.* "But something will have to give," Zimmerman has told MEDICAL ECONOMICS "because the situation is getting worse every day." END

*For Dr. Draper's stand, see "'Free Choice Has Failed,'" MEDICAL ECONOMICS, Jan. 20, 1958.

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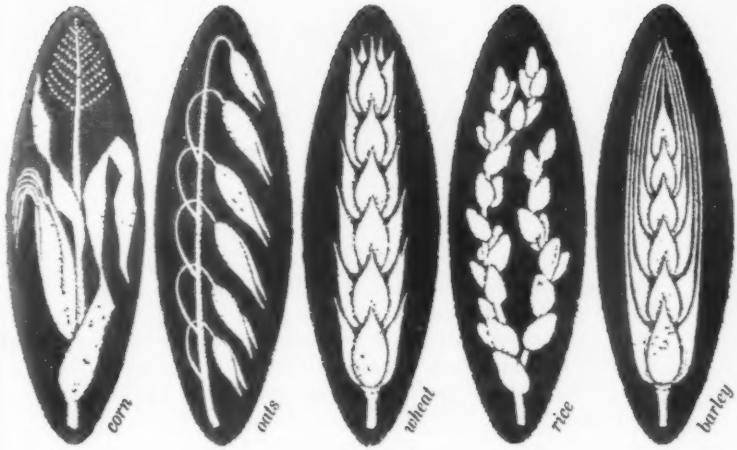

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Memo

FROM THE EDITORS

Coming in April During the next two weeks, you'll be working up your Federal income tax return—with the help, we hope, of the cover story in this issue. Just about when you're through, on April 14, a new issue of MEDICAL ECONOMICS will arrive. And another will reach you on April 28. Among their highlights:

How Much Professional Courtesy for Non-M.D.s?

This survey of 1,000 doctors shows the extent to which they give free care to 36 different kinds of patients—clergymen, dentists, druggists, hospital associates, medical students, nurses, etc.

They're Ready to Testify for the Plaintiff

Panels of doctors throughout one state will provide impartial testimony in malpractice cases. It's a promising answer to the 'conspiracy of silence' charge. It may even help hold down court awards

Formula for a Hospital Staff

How many doctors should be on it? What kinds of doctors? Here are new yardsticks based on an original study of hospital bed usage by G.P.s and specialists in the major fields of practice

How Do You Want Your Life Insurance Paid?

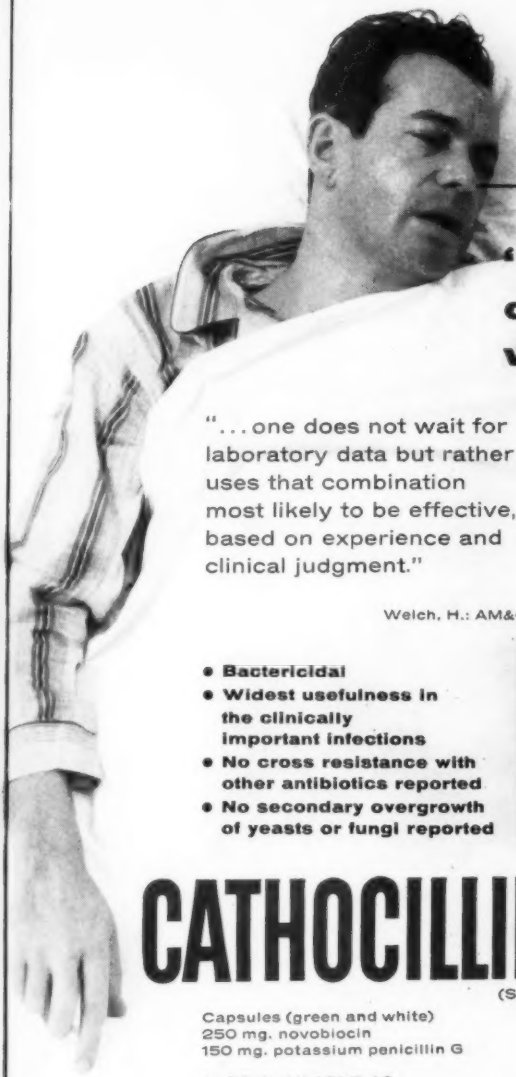
You can choose whether your family is to get the proceeds in a lump sum or in installments. Make sure you choose right. Here's how

New Answer to High Malpractice Rates

One state's physicians have started their own malpractice insurance company. First premiums: 25 per cent below prevailing rates. Will the idea spread to other states? Will it hold down costs as hoped?

Does Medical Writing Pay Off?

The rewards are great, says this medical editor. But if your aim is fast royalties, you'd better check this detailed summary of present-day writing expenses first. It's cheaper to buy a new automobile



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